Lower Umpqua Hospital District (LUHD)
SARS-CoV-2 (COVID-19) Immunization
Authorization to Release Information and Acknowledgment

Print legibly:

Last name:	**Date of Birth:**
	Birth sex ☐ Male ☐ Female
First name:	**Telephone #:**
Street Address	**City, State, Zip Code**

Please answer the following questions:

1) Are you age 15 or older?	☐ **Yes**	☐ **No**
2) Are you ill or with a temperature **greater than/equal to** 100.0°F today?	☐ **Yes**	☐ **No**
3) Do you have any chronic health conditions; i.e., heart disease, lung disease, liver disease, or diabetes? If yes, explain:	☐ **Yes**	☐ **No**
4) Have you ever had a seizure, a brain disorder, Guillain-Barre syndrome or other nervous system problem? If yes, explain:	☐ **Yes**	☐ **No**
5) Have you ever received a dose of COVID-19 vaccine? If yes, indicate brand and date of vaccine:	☐ **Yes**	☐ **No**
6) Have you had any previous severe allergic reaction (e.g., anaphylaxis) to any of the following that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital? It also includes an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing? • **Polyethylene glycol (PEG)**, which is found in some medications, such as laxatives and preparations for colonoscopy procedures. • **Polysorbate**, which is found in some vaccines, film coated tablets, and intravenous steroids. • Previous dose of COVID-19 vaccine or other vaccine or injectable therapy. • A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction. • Any other medical treatment or environmental allergy.	☐ **Yes**	☐ **No**
7) Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? If yes, date of treatment:	☐ **Yes**	☐ **No**
8) Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐ **Yes**	☐ **No**
9) Do you have a bleeding disorder or are you taking a blood thinner?	☐ **Yes**	☐ **No**
10) Are you currently pregnant or breastfeeding?	☐ **Yes**	☐ **No**
11) Do you have dermal fillers?	☐ **Yes**	☐ **No**
12) Have you ever been diagnosed with COVID-19? If yes, date of diagnosis:	☐ **Yes**	☐ **No**

I appreciate that it is not possible to consider every possible complication of vaccination. I have had an opportunity to ask questions about this vaccination and understand the most current information sheet on vaccinations is available to me. **I understand this information and my questions have been answered to my satisfaction. I understand the benefits and risks of the COVID-19 vaccine and request the vaccine be given. I CONSENT to informing my insurance carrier, LUHD and the State Immunization Registry that I have received the COVID-19 vaccine.**

Signature of Person Receiving the Vaccine or Parent/Guardian (under age 15):	**Date**	**Time**

Administrator Use Only

☐ Dose **1** ☐ Dose **2** ☐ Dose **3** for immunocompromised ☐ Booster dose

Site of Injection (IM): ☐ Right Deltoid ☐ Left Deltoid

Indicate Vaccine Manufacturer, Lot # & Expiration Date	☐ Pfizer ☐ Moderna US, Inc. ☐ Pediatric Pfizer	**Lot #**	**Expiration Date:** ☐ Employee of LUHD
		Administered by (printed name):	
Date:	**Time**:	**Signature:**	