Mountainlands Family Health Center

COVID-19 Immunization Form

Patient Name:_____**Date of Birth:**_____**Age:** _____

Phone#: (_____)_____-_____ **Gender:** Male Female

Race (Circle): African American Alaskan Native Asian/Pacific Islander NativeAmerican White Other

Ethnicity: Hispanic? Yes No

Please answer these questions concerning the individual receiving immunizations today	***Yes***	***No***
Are you moderately to severely sick and/or have you had a fever within the last 24 hours?		
Have you had a serious allergic reaction in the past (anaphylaxis)?		
Have you ever had an allergic reaction (of any severity) to mRNA COVID-19 vaccine, or any of its components including polyethylene glycol (PEG) or polysorbate?		
Have you been diagnosed/treated for COVID-19 in the last 2 weeks?		
HAVE YOU RECEIVED A PREVIOUS DOSE OF COVID-19 VACCINE? IF YES, WHAT DATE?		

Please Initial and Sign the Following:

I have been given a copy and have read or had explained to me the information contained in the **Vaccine Information Statement(s**) about the disease(s) and vaccine(s). Any questions I had were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I hereby request that the vaccine(s) indicated be given to me or the person for whom I am authorized to make this request. I certify that I have received a copy or been given the opportunity to read the **Notice of Privacy Practices.** I understand that immunization records may be shared with schools, day care centers, health care providers, and other reasonably pertinent organizations/authorities to verify immunization status. This information may be shared with State of Federal Public Health officials or studies when medically necessary or for record- keeping purposes.

_____ I understand that I should not have any screening mammograms for up to 4 to 6 weeks after receiving the vaccine.

_____ I understand that I should **wait 15-30 minutes after receiving the vaccine**.

Authorization Signature:_____**Date:** _____

For internal use only

Vaccine Administration Record:

Vaccine	Dose in Series	Lot Number/Exp. Date	Site	Date	Administered By	Checked
☐PFIZER-BIONTECH COVID-19 Vac (12+) Adult/Adol 30mcg/0.3mL ☐PFIZER-BIONTECH COVID-19 Vac (5-11) Pediatric 10mcg/0.2mL ☐OTHER:	☐ 1st ☐ 2nd ☐ 1st Booster ☐ 2nd Booster ☐ OTHER:		☐L DELT ☐R DELT ☐Other:			