ENGLISH

Vaccine Type P1 P2 M1 M2 J	Patient ID	Reg Desk ID	Injector ID or Name	L/R arm or X if not vax'd	Extended Observation

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Welcome!

		Yes	No
1.	Do you have any of the following symptoms in the last 10 days: fever, (>100.4F), chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new altered sense of taste or smell, sore throat, congestion or runny nose, nausea, vomiting or diarrhea?	☐	☐
2.	Have you ever received a COVID -19 vaccine?	☐	☐
3.	Do you have a serious allergy to ANY medications, food or latex (e.g. eggs, gelatin, thimerosal, neomycin, gentamicin, etc.)?	☐	☐
4.	Have you ever had a serious reaction or fainted after receiving any vaccination?	☐	☐
5.	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐
6.	Have you received another vaccine in the last 14 days?	☐	☐
7.	Have you tested positive for COVID-19 test in the last 2 weeks?	☐	☐
8.	Do you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list: ______________________________	☐	☐
9.	Are you pregnant or breastfeeding?	☐	☐

Informed Consent and Screener for COVID-19 Immunization

Informed Consent: *Please read and sign.*

By my signature below, I consent to the administration of the vaccine. I also release **Urgent Care Now** and affiliates, employees, and volunteers from all liability, including acts of omission or commission, resulting, or arising from my receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination. 2) I am of legal age and authorized to execute this consent form. 3) I will immediately alert the vaccine administrator of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine. 4) I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 5) I should remain in the area for 15 minutes after the vaccination for observation or 30 mins if I have reported severe allergies or reactions to medications, food vaccines or latex. 6) I have read, or have had read to me, the fact sheet provided for the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). 7) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting to an immunization registry, which may share my immunization data with others or the local Department of Health, if applicable, and I authorize these disclosures.

______________________________ Patient Legal Name

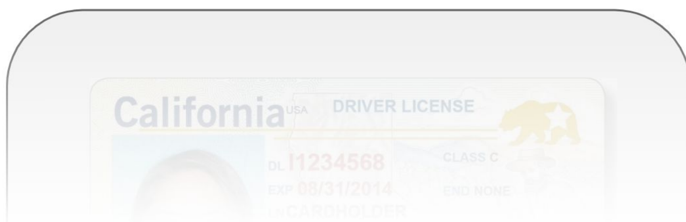
______________________________ Patient Signature

_____/____/_______ Date

______________________ ZIP Code

_____/____/_______ Date of Birth

______________________________ Parent Signature (if patient < 18 years)



Clinic will scan ID

It's OK if you don't have ID

Clinic will scan insurance

It's OK if you don't have insurance