PULLMAN REGIONAL HOSPITAL

COVID-19 Vaccine Patient Acknowledgment

Patient Name (Last, First): ____ DOB: ____/____/________

Phone: ____________________ Mobile Phone: __________________________Email: ___________________________________
(This information will be used to contact you for your second dose reminder.)

Address: _____________________________________ City, State, Zip Code: ____

Information collected in this section helps ensure we deliver equitable and patient-centered care:
Sex listed at birth (check one):

Male: ☐	Female: ☐

Gender identity (check one):

Male: ☐	Female: ☐	Non-Binary ☐	Unspecified/Indeterminant: ☐

Ethnicity (Check one):

Hispanic or Latino (Including Spanish, Mexican, Puerto Rican, Cuban, etc.) ☐	Not-Hispanic A person not of Spanish culture or origin ☐

Race: (Check all that apply):

Black or African American ☐ White ☐	Asian ☐ American Indian or Alaska Native ☐	Hawaiian or Pacific Islander ☐

Preferred language:

English ☐	Spanish ☐	Russian ☐	Ukrainian ☐	Vietnamese ☐	Tagalog ☐	Other: ______________ ☐

Acknowledgements:

- *I made the choice to get the COVID-19 vaccine on my own and freely. I know I have the option to refuse the vaccine. I ask that the vaccine be given to me, or to the person named above for whom I can make this request. I was given the (Fact Sheet for Vaccine Recipients and Caregivers)* for this vaccine. The fact sheet *has information about side effects and adverse reactions. I read or had read to me the information provided about the COVID-19 vaccine.*
- *I know the Food and Drug Administration (FDA) has authorized the emergency use of this vaccine. I know it is not a fully licensed FDA vaccine. I had the chance to ask questions that were answered to my satisfaction. I now know about the vaccine, alternatives, benefits, and risks, to the extent they are known and unknown at this time.*
- *I know that I must stay in the vaccine area or an area told to me by my health care provider after I receive my immunization so I am near my health care provider if I have any adverse reactions. If I have a history of certain allergic reaction(s), I must stay for 30 minutes. If I do not have a history of such an allergic reaction(s), I must stay for 15 minutes.*
- *I know that if I have a severe allergic reaction, including difficulty breathing, swelling of my face and/or throat, a fast heartbeat, a bad rash all over my body or dizziness and weakness I should call 9-1-1 or go to the nearest hospital. I know I can call my health care provider if I have any side effects that bother me or do not go away.*
- *I was asked to join the V-SAFE program. The program does health checks on the people who get the COVID-19 vaccine. I know I should report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 or https://vaers.hhs.gov/reportevent.html.*
- *I know that with all vaccines there is no promise I will become immune (not get the virus) or that I will not have side effects.*
- *If my COVID-19 vaccine is a two-dose vaccine, know I must get two doses and receive the same vaccine each time. I know I may choose to not get the second dose of the vaccine. But if I do not get the second dose, the chance that I will become immune may go down.*

Authorization to Request Payment: *I authorize the organization providing my vaccine to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.*

Disclosure of Records: *I understand the organization providing my vaccine may be required to or may voluntarily disclose my vaccine-related health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also understand the organization providing my vaccine will use and disclose my health information as described in its Notice of Privacy Practices which I may receive upon request or find on its website. If I am an employee of Pullman Regional Hospital, I understand that it will keep records of this vaccination for me and may keep my vaccination records in Pullman Regional Hospital's employee occupational health records, to the extent required or permitted by law.*

Patient (or Parent/Guardian/Authorized Representative) Signature: _____________________________ Date: _________________

Name of Parent, Guardian or Authorized Representative: _____________________________________ Date: _________________

If you are signing on behalf of the patient, you are stating that you are authorized to make the required decisions on behalf of the patient

All sections below are for official use only:

Vaccine Administration Information for Immunizer: Dose #1

Vaccine administering provider suffix: ____________________________________

Vaccine administering site on the body: Left deltoid □

Right deltoid □

Other □ (indicate location) ________

Vaccine expiration date: _________________

Vaccine Administration Information for Immunizer: Dose #2

Vaccine administering provider suffix: ____________________________________

Vaccine administering site on the body: Left deltoid □

Right deltoid □

Other □ (indicate location) ________

Vaccine expiration date: _________________

VACCINE DOSE: 1st ☐ 2nd ☐ If this is your 2nd dose, what vaccine was your 1st? Pfizer ☐ Moderna ☐
When did you receive your 1st dose? (date):___________________________________

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name ____________________

Age __________

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.
If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product ____________			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of a COVID-19 vaccine including either of the following:			
○ 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.			
• A previous dose of COVID-19 vaccine.			
• 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.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Form reviewed by ____________________ **Date** ____________