KLICKITAT COUNTY HEALTH DEPT COVID-19 VACCINE ACKNOWLEDGEMENT RECORD

Name: (Last, First, MI)	**Age:**	**Date of Birth:**
Mailing Address:	**Telephone No.**	**Male Female Other:**
City:	**State:**	**Zip:**
Race: Check all that apply □Black or African American □Asian □American Indian or Alaska Native □ Hawaiian or Pacific Islander □White		**Ethnicity** □ Hispanic or Latino □Not Hispanic or Latino
If this is your second dose, when did you receive your first dose? (date): _____	**Vaccine Dose (check one): 1st □ 2nd □**	
If this is your second dose, what vaccine was your first? □Pfizer □Moderna □ Don't know		
Primary Care Provider:	**Fact Sheet for Vaccine Recipients Version date: 12/20**	

- *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 severe allergic reaction, (e.g. anaphylaxis), I must stay for 30 minutes. If I do not have a history of severe allergic reaction, 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 I must get two doses of the COVID-19 vaccine and receive the same vaccine each time. 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. 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.*

Answering yes to either of these questions excludes you from receiving the vaccine.

Do you have a known history of a severe allergic reaction (e.g. anaphylaxis) to this vaccine or any components of the vaccine such as lipids, potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose? (Full list is available in the *Fact Sheet for Vaccine Recipients and Caregivers* or from your health care provider.)	Yes	No
Are you under the age of 16 years?	Yes	No

If patient answers "yes" to any of the below, provide patient counseling to prior to receiving the vaccine.

In the past two weeks have you tested positive for COVID-19?	Yes	No
In the past two weeks have you had exposure to a person who tested positive for COVID-19 at a distance of six feet or less for a period of 15 or more minutes without wearing appropriate personal protective equipment?	Yes	No
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?	Yes	No
In the past 90 days have you received passive antibody therapy as part of COVID-19 treatment?	Yes	No
Are you pregnant or breastfeeding or do you plan to become pregnant?	Yes	No
Are you immune compromised or on a medicine that affects your immune system?	Yes	No
Do you have a bleeding disorder or are you on a blood thinner?	Yes	No
Do you have a history of severe allergic reaction (e.g. anaphylaxis) to another vaccine or injectable medication? If yes, what vaccine or injectable medication:	Yes	No

Have you received another vaccine in the last 14 days	Yes	No

Insurance Information:

Insurance company: _____ Are you the primary card holder? Y N

If no, what is the primary card holders name and date of birth? _____

Cardholder ID: _____

Are you Medicare eligible? Y N If yes, Medicare Part A/B number: _____

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.*

Patient Signature: _____ Date:_____

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To Be Completed by Administering Staff Only

Vaccine Administration Information

Administration date: _____ Administration time: _____

Vaccine : Moderna Dose number: 1 2

Lot number: 037K20A Manufacturing date: 11/22/20 Expiration Date: 6/22/2021

Vaccine administration site: □ Right deltoid IM □ Left deltoid IM

Clinic Site/Location ____Goldendale HD ____White Salmon HD ____ Other: _____

Signature\Title of vaccine administrator:

_____RN Date: _____