COVID-19

Vaccine Acknowledgment Form

DECEMBER 13, 2021

1. Have you ever received a dose of COVID-19 Vaccine?

   ☐ Yes ☐ No

   If yes, which product?

   ☐ Pfizer ☐ Moderna ☐ Other____________________

2. Have you tested positive for COVID-19 within the past 14 days or received COVID-19 monoclonal antibody therapy within the past 90 days?

   ☐ Yes ☐ No

3. Which vaccine do you wish to get today?

   ☐ Initial series (Pfizer 12- older, Moderna 18-older, Johnson & Johnson 18-older)

   ☐ Booster (Pfizer 16-older, Moderna 18-older, Johnson & Johson 18-older)

   ☐ Immunocompromised 3rd dose (Pfizer 12-older, Moderna 18-older)

   ☐ 5-11 year Pediatric (Pfizer)

4. Are you pregnant or breastfeeding?

   (If you are pregnant or breastfeeding you may be vaccinated but should discuss this with your healthcare provider before taking the vaccine.)

   ☐ Yes ☐ No

5. Have you participated in a COVID-19 vaccine trial?

   ☐ Yes ☐ No

6. Are you immunocompromised or on a medication that affects your immune system?

   ☐ Yes ☐ No

7. Have you previously had an anaphylactic reaction that requires you to carry an Epipen?

   (If yes, please notify the Charge RN. You must be observed in the vaccination area for 30 minutes after the administration of your vaccine.)

   ☐ Yes ☐ No

I acknowledge that I have read and understand the information provided in the FDA Fact Sheet "Emergency Use Authorization (EUA) of the COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19)."

Signature of Patient	**Printed Name**	**Date**

Complete below only if person receiving the vaccine is under 18.

Signature of Parent or Patient's Legal Guardian	**Printed Parent or Legal Guardian Name**	**Patient's Date of Birth**

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LEFT DELTOID   RIGHT DELTOID   1st   2nd   3rd   Booster

Administered by: ______________________________ Date: ________________________

MFG:_____________________
LOT:_____________________
NDC:_____________________
EXP:_____________________