PAMPA VACCINE QUESTIONNAIRE

Patients's Name:	**Phone:**
Street Address:	

City:	**County:**	**State:**	**Zip:**
Please Circle One: Female Male	**Patient's Date Of Birth: (month/day/year)** _____/_____/_____	**Patient's Age:**	

ANSWER THE FOLLOWING QUESTIONS ABOUT THE PERSON RECEIVING THE IMMUNIZATION	**YES**	**NO**	**DO NOT KNOW**	**N/A**
Is the patient sick today?				
Does the patient have allergies to latex, medications, food or any vaccine?				
Has the patient had a serious reaction to the vaccine in the past?				
Has the patient had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes) asthma, a blood disorder, or taking blood thinners?				
Has the patient, a sibling, or a parent had a seizure, has the person had a brain or other nervous system disorder?				
Does the patient have cancer, leukemia, AIDS, or any other immune system problem?				
In the past 3 months, has the patient taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?				
In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or and antiviral drug?				
Has the patient received a vaccine in the past 2 weeks?				

Vaccine to be administered: _____ **Covid19 vaccine:** _____

I have been given a copy and have read, or have had explained to me, the Vaccine Information Statement(s) for the vaccine(s) inidicated above. I have been given the opporunity to ask questions and they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request it/they be given to me or the patient named above for whom I am authorized to make this request. I understand that it is recommended to wait at least 30 minutes at the clinical site after receiving the immunization in case of a reaction of the vaccine. I have been given the opportunity to review and/or receive, a copy of the request of, the Notice of Health Information Practices from the County Board of Health regarding my health information rights and the Board of Health responsibilties and I authorize the release of any medical or other information necessary for care, treatement and claim processing. I authorize payment of medical benefits to the undersigned physician, supplier or party who accepts assignment for services described.

Authorized Patient/Guardian SIgnature:		**Date:**	
Covid19 Vaccine Lot #:	**Expiration:**	**Manufacturer**	**Pfizer**
Dose/Route:	**IM L _____ R _____ Deltoid**	**VIS provided online**	
Nurse Signature:	**Date:**		