Kittitas County COVID-19 Vaccine Acknowledgement Form

NAME (Last)	(First)	(M.I.)	**Date of Birth** **Age**
Address	**City**	**State**	**Zip Code**
Email address	**Phone**	**Sex** ☐ Male ☐ Female ☐ Transgender ☐ Other	
Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Native Alaskan ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unknown ☐ Prefer not to answer **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer			

Acknowledgments:

- 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 for ages 5-15. 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 after I receive my immunization so I am near the healthcare team 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 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 or booster dose of the vaccine. But if I do not get the second or booster dose, the chance that I will become immune may go down.
- Disclosure of Records: I 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 the organization's website.

Patient (or Parent/Guardian/Authorized Representative)

Signature: _____ Date: _____

Name of Parent, Guardian or Authorized Representative:

_____ Date: _____

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Pre-Vaccination checklist for COVID-19 Vaccines

If you answer yes to any of the questions below, we recommend you consult with your healthcare provider prior to vaccination**.**

1. Are you feeling sick today?	Yes	No
2. Have you ever received a dose of COVID-19 vaccine? If so, when? _____	Yes	No
* If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Another product _____	Yes	No
3. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?	Yes	No
• Was the severe allergic reaction after receiving a COVID-19 vaccine?	Yes	No
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?	Yes	No
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	Yes	No
5. Have you received another vaccine in the last 14 days?	Yes	No
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	Yes	No
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	Yes	No
8. Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No
9. Are you pregnant or breastfeeding?	Yes	No

For clinic use only:

Vaccine Manufacturer	Lot Number	Expiration Date	IM Site LD-Left Deltoid RD- Right Deltoid	Dose
Pfizer				

Vaccinator Name/Title: _____ Date: _____

Site location: Kittitas County Public Health

☐ Entered into WAIIS

Last Update: 10.25.2021

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