Virginia Garcia Memorial
HEALTH CENTER

COVID-19 Vaccine Acknowledgment (Patient)

VIRGINIA GARCIA MEMORIAL HEALTH CENTER
PO BOX 6149
ALOHA, OREGON 97006

This information is for the person getting the vaccine:

Last Name: _____ First Name: _____ DOB: _____

Previous last name, if any: _____ Cell Phone: _____ Other Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____

	Yes	No	Don't Know
1. **Have you ever had a dose of COVID-19 vaccine?**			
• If yes, which vaccine product did you receive? ☐Pfizer ☐Moderna ☐Another product			
2. **Have you received any vaccine in the last 14 days?** (Stop- do not vaccinate)			
3. **Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?**			
• If yes, were you given antibody therapy in the last 90 days? (Stop- do not vaccinate)			
• If yes, was your positive test in the last 10 days? (Stop- do not vaccinate)			
4. **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?**			
• If yes, was the severe allergic reaction after receiving a COVID-19 vaccine? (Stop- do not vaccinate)			
• If yes, was the severe allergic reaction after receiving another vaccine or another injectable medication?			
5. Have you ever fainted after injections?			
6. Do you have any of the following conditions? ☐ Feeling sick, fever, chills, cough **today** ☐ Weakened immune system or taking medicine that affects your immune system ☐ Bleeding disorders or taking blood thinners ☐ Pregnant or breastfeeding			

01/05/2021 CS321629-E Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklist

CONSENT: I have received the Emergency Use Authorization (EUA) form. I have reviewed the information provided and have had my questions answered. I am voluntarily receiving the vaccine and know what to do if I have side effects. I understand that Virginia Garcia is required to share information about the vaccine I receive with the state vaccine registry.

For official use only: Vaccine Administration Documentation

Person administering vaccine (name & credential): _____ Vaccine given: ☐Pfizer ☐Moderna ☐Another product

_____ Dose & unit: _____ Lot number: _____

Administration time: _____ Administration date: _____ Route: _____ Vaccine expiration date: _____

Site: ☐ Left deltoid ☐ Right deltoid Other (indicate location) _____ EUA version date: _____