COVID-19 DOSE 1 VACCINATION RECORD - Singing River Health System

PATIENT INFORMATION

Name: _____ DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ ZIP: _____

Contact Phone Number: _(_____)_____

Email Address: _____

Insurance Policy Holder: _____

Insurance Policy #: _____ Insurance Plan: _____

Required by the CDC:

Race *(select all that apply)*		Ethnicity *(select all that apply)*
☐ American Indian/Alaskan Native	☐ White	☐ Hispanic or Latino
☐ Asian	☐ Other Race	☐ Not Hispanic or Latino
☐ Native Hawaiian or Pacific Islander	☐ Unknown	☐ Unknown
☐ Black/African American	☐ Unable to Report	☐ Unable to Report

Have you ever had a reaction to a vaccination?	Yes	No
Have you tested positive for COVID-19?	Yes	No
If yes, are you outside the 10-day quarantine period?	Yes	No
Have you had a vaccination within the past 14 days?	Yes	No
Are you pregnant, or planning to get pregnant?	Yes	No

I have been given a copy of the vaccination consent form. I have read it or it has been read to me. I understand the information and have had my questions answered. I understand the potential risks and benefits of the COVID-19 vaccine and request that the vaccine be given to me. I agree to hold Singing River Health System harmless from any injury, complications or side effect(s) caused by administration of said vaccine. I have been informed that I should remain at the vaccination location for 15 minutes to confirm I have no immediate adverse reactions from the vaccine I received. I understand that if I leave the vaccination location before 15 minutes have elapsed, I do so against the instruction of Singing River Health System.

_____ _____
Signature of Participant Date

_____ _____
Signature of Person Reviewing Consent Date

Vaccine	Date Dose Administered	Injection Site	Vaccine Manufacturer
2020-2021 COVID-19 Vaccine		Left Arm Right Arm	PfizerBioNtech