TCHD COVID19 ENCOUNTER

DATE OF SERVICE: _____ ☐ **INS**

Name: _____ Date of Birth: _____ Age: _____ Sex: M/F

Address:_____City_____State_____Zip_____

Phone: _____ Cell Phone:_____ Race:_____

Primary Insurance: _____ ID/Policy #: _____

Complete for person receiving the vaccine:

Yes	No	
☐	☐	Are you sick today?
☐	☐	Has had a serious allergy to any foods or medications?
☐	☐	Has had a serious reaction to a vaccine in the past?
☐	☐	Is on aspirin therapy, chemo/radiation therapy?
☐	☐	Has been paralyzed by Guillain-Barre Syndrome, had a seizure or nervous system problem?
☐	☐	Has had immunizations in the last month.
☐	☐	Has been sick in the last week, on an antibiotic or antiviral medication.
☐	☐	Is pregnant, or has a chronic illness such as heart disease, lung disease, diabetes, asthma, kidney or liver disease, anemia or other blood disorder.
☐	☐	Do you or anyone you live with have a weakened immune system?
☐	☐	Are you under 18 years of age?

I have been given a copy and have read, or had explained to me, the information contained in the Vaccine Information Statement about the disease and vaccine. I understand the benefits and risks of the vaccine and request that the vaccine be given to me or the person for whom I am authorized to make this request. I agree that this information may be shared with schools, daycare centers, healthcare providers and others when medically necessary. I have been given a copy of the Tooele County Health Department's Notice of Privacy Practices and have had a chance to ask questions about how my public health information will be used. I understand that it is my responsibility to know what my insurance plan covers and agree to pay the portion not covered by my insurance. I understand that if Tooele County Health Department does not have a contract with my insurance company, or my insurance company denies payment, I am responsible for all charges incurred.

Client/Guardian Signature: _____ Date_____

**** Space below for Public Health Nursing Information Only****

X	Vaccine	Lot #	Site	
	Moderna		**T D L R**	
	Pfizer/BioNTech		**T D L R**	
	Johnson& Johnson		**T D L R**	
			T D L R	
			T D L R	

Nurse:_____Clerk:_____