

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:

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you sick today? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has had a serious allergy to any foods or medications? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has had a serious reaction to a vaccine in the past? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is on aspirin therapy, chemo/radiation therapy? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has been paralyzed by Guillain-Barre Syndrome, had a seizure or nervous system problem? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has had immunizations in the last month? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has been sick in the last week, on an antibiotic or antiviral medication? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is pregnant, or has a chronic illness such as heart disease, lung disease, diabetes, asthma, kidney or liver disease, anemia or other blood disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you or anyone you live with have a weakened immune system? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 (Under 12 years old)		T D L R	
	Novavax (12 & older)		T D L R	
			T D L R	
			T D L R	
			T D L R	

Nurse: _____

Clerk: _____