COVID-19 Vaccine Screening and Agreement

Information collected on this form will be used to document that you have received vaccine(s). Information about your vaccine(s) may be shared through the Minnesota Immunization Information Connection (MIIC) with other health care providers, schools, health departments, and others authorized under law to receive it. If you have any questions, please ask your doctor or other health care provider. If you have questions about MIIC, refer to MIIC and the Public (www.health.state.mn.us/people/immunize/miic/public.html) or call 1-800-657-3970.

Assignment of benefits and responsibilities for payment: This lets us bill your health plan or company and to receive payment directly. It also means that you agree to pay for services not covered by your health plan. There is no cost for the COVID-19 vaccine, although you may be billed an administration fee.

I authorize this health provider to bill my health plan or other payers on my behalf, and to receive payment of authorized benefits.

Contact information – person being vaccinated

Patient's name (last, first, middle): ______________________________

Date of birth: ______________________________

Primary phone number: ______________________________

Address (street or P.O. Box): ______________________________

City: ______________________________

State: ______________________________

ZIP code: ______________________________

Parent's name (last, first, middle - if younger than 18 years): ______________________________

Payment information Bring a copy of your insurance card with you!

Primary insurance carrier: ______________________________

Policy/ID/member number: ______________________________

Group number: ______________________________

Secondary insurance carrier:

Policy/ID/member number: ______________________________

Group number: ______________________________

Policy holder, if different from the person getting vaccinated:

Name: ______________________________

Date of birth: ______________________________

☐ Check here if person getting the vaccine does not have insurance.

Agreement

By signing below, I understand, recognize, approve, and agree that:

- I have received and read or had explained to me the Emergency Use Authorization Fact Sheet for the following COVID-19 vaccine: [Insert name of vaccine product].
- I have had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described.
- I agree to receive the COVID-19 vaccine for myself or for the person named above.

Signature of patient or parent/guardian: ___________________________________ Date: ___/___/____

Health history

Yes	No	Unknown	Question
Yes	No		Do you want to receive a COVID-19 vaccine today?
Yes	No		Are you the correct age to receive the COVID-19 vaccine? • Pfizer-BioNTech vaccine: You must be 12 years or older. • Moderna vaccine: You must be 18 years or older.
Yes	No	Unknown	Have you been diagnosed with COVID-19 infection in the past 90 days?
Yes	No	Unknown	Are you feeling sick today?
Yes	No	Unknown	Have you received any other vaccines (that were not COVID-19 vaccine) within the past 14 days?
Yes	No	Unknown	Have you had a known exposure to someone with COVID-19 in the past 14 days?
Yes	No	Not applicable	Are you pregnant?
Yes	No	Not applicable	Have you ever received a dose of COVID-19 vaccine? If yes, list vaccine product and date received:
Yes	No	Unknown	Did you have a severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine?
Yes	No	Unknown	Immediate allergic reaction (within 4 hours) of any severity to a previous COVID-19 vaccine dose or known (diagnosed) allergy to a component of the vaccine or any of its ingredients (including polyethylene glycol [PEG] or polysorbate)?
Yes	No	Not applicable	Did you have a delayed allergic reaction at the injection site (e.g., redness, itching) after a first dose of COVID-19 vaccine?
Yes	No	Unknown	Immediate allergic reaction to any other vaccine or injectable therapy (e.g., shots in the muscle (intramuscular), in the vein (intravenous), or into the fatty tissue (subcutaneous)? Does not include allergy shots.
Yes	No	Unknown	Received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days?

PATIENT/PARENT DO NOT WRITE BELOW THIS LINE

Vaccine information

COVID-19 Vaccine Presentation[1]	EUA Fact Sheet Date	Route[2]	Manufacturer[3]	Lot Number	Admin Site[4]	Person Admin[5]
COVID-19 (Pfizer)		IM	PFR			
COVID-19 (Moderna)		IM	MOD			

1. **COVID-19 Vaccine Presentation** = lists specific product name (e.g., Pfizer, Moderna, etc.)
2. **Route:** IM = Intramuscular
3. **Manufacturer:** MOD = Moderna, PFR = Pfizer
4. **Site Vaccine Given:** LD = Left Deltoid, RD = Right Deltoid, LT = Left Thigh, RT = Right Thigh
5. **Signature or initials of person administering vaccine:** Can be used if more than one person is administering vaccines.

Signature and title of person administering vaccine: ____

Date administered: ___/___/_______