PROVIDER:_____ SPOT:_____

Covid -19 Vaccine Screening and Agreement

Information collected on this form will be use to document that you have received vaccine(s). Information about your vaccine/s may be shared through the Minnesota Immunization information Connection (MICC) 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 overed by your health plan. There is no cost for the COVID -19 vaccine, although you may be billed and 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.

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CONTACT INFORMATION- person being vaccinated

Patient Name (last, first Middle) _____ Date of birth: _____

Primary Phone number: _____Parents Name (last, first, middle if under 18 yrs.) _____

Address (street /PO Box): _____**City: _____State: _____ Zip_____**

Payment information: Bring 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 vaccinated does not have insurance**

Agreement

By signing below, I understand, recognize, approve and agree that: I have received, read or had explained to me the Emergency Use Authorization Fact sheet of the following COVID-19 vaccine

(circle one) Pfizer BioNTech Covid -19 Moderna Covid -19

I have had a chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COID 19 vaccine as described.

I agree to receive the COVID -19 vaccine for myself or the person named above.

Signature of patient/Guardian: _____ Date: _____

Yes	No	Unknown	Question- **please answer all questions**
Yes	**No**		Do you want to receive a **Pfizer BioNTech** OR Moderna COVID-19 Vaccine today? **(circle one)**
Yes	**No**		Are you or your child receiving this vaccine at least 16 years old= Pfizer or 18 years or older= Moderna?
Yes	**No**	**Unknown**	Have you been diagnosed with COVID -19 in the last 90 days?
Yes	**No**	**Unknown**	Are you feeling sick today?
Yes	**No**	**Unknown**	Have you received any other vaccines (that were not COVID-19 in 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**	**Unknown**	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**	Have you ever had an *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**	Have you had an *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**	Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the last 90 days?

Vaccine Information

COVID-19 Vaccine Presentation	EUA fact sheet Date	ROUTE	Manufacturer	LOT number	Admin site	Person Admin
Covid -19 Pfizer-BionTech		**IM**	**Pfizer**			
Covid -19 Moderna		**IM**	**Moderna**			

Covid -19 Vaccine presentation=Lists specific product name (e.g., Pfizer, Moderna, etc.)
Route: IM= intramuscular
Manufacture: MOD= Moderna, PFR=Pfizer-BioNTech
Site Vaccine Given: LD= left deltoid, RD= Right deltoid, LT= left Thigh, RT=Right thigh
Signature or initials of person administering vaccine: Can be used if more than one person is administering vaccines.

Signature/title of person administering Vaccine: _____Date_____