Sugarloaf Medical, P.C.
2020-2021 COVID-19 Vaccine Administration Form

Demographics: Name (Please print name neatly)

Last:	First:	Address:

Gender: ☐ F ☐ M	Date of Birth: _____/_____/_____	Phone#:	E-mail:

Insurance Information (for new patient's)

Insurance Name:	Policy Number:	Group Number:

Screening Questionnaire for COVID-19 Vaccination: The following questions will help us determine if there is any reason that we should not give you the vaccine today.

1. Are you feeling sick today ?	☐Yes	☐No
2. Have you ever received a dose of COVID-19 vaccine?	☐Yes	☐No
• If yes, which vaccine product? ☐Pfizer ☐Moderna ☐Another Product _____		
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?	☐Yes	☐No
• Was the severe allergic reaction after receiving a COVID-19 vaccine?	☐Yes	☐No
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?	☐Yes	☐No
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐Yes	☐No
5. Have you received another vaccine in the last 14 days?	☐Yes	☐No
6. Have you tested positive for COVID-19 or has a doctor ever told you that you had COVID-19?	☐Yes	☐No
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐Yes	☐No
8. Do you have a bleeding disorder or are you take a blood thinner?	☐Yes	☐No
9. Are you pregnant or breastfeeding?	☐Yes	☐No

COVID-19 EUA Fact Sheet For Recipients Acknowledgement: Pfizer (12/12/2020/ Moderna (12/20/2020)

☐ **I have reviewed the COVID-19 vaccine Fact Sheet for Recipients**

COVID-19 Vaccine Administration & Release

I understand the FDA has authorized the E*mergency Use* of the COVID-19 vaccine, which is not an FDA-approved vaccine. I have reviewed, or have had explained to me, the information in the FDA Fact Sheet on this vaccine. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccination as described; that this vaccine requires two doses; that two doses will need to be administered in order for the vaccine to be effective.

I request and consent to the Emergency Use COVID-19 vaccination being administered/given to me by Sugarloaf Medical P.C., through its designated agents or representatives. I authorize release of all information needed (included but not limited to medical records, claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.
I hereby release Sugarloaf Medical, P.C. and its employees from any and all liabilities in connection with this vaccine and the administration to me.

I acknowledge that no guarantee or assurance has been made to me concerning any potential results from the administration of this vaccine. SUGARLOAF MEDICAL, P.C., BY ADMINISTERING THE VACCINE TO ME PROVIDES NO WARRANTY WITH RESPECT TO THE VACCINE AND SUGARLOAF MEDICAL, P.C. SPECIFICALLY DISCLAIMS ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE CONCERNING THE VACCINE.

☐ **I consent to the administration of the COVID-19 vaccine by Sugarloaf Medical, P.C.**

Name of person receiving vaccine (Please print legibly)	**Signature of person receiving vaccine**	**Date**

For Office Use Only:

Moderna: ☐ 1 ☐ 2
☐Right Arm ☐Left Arm

Pfizer: ☐ 1 ☐ 2
☐Right Arm ☐Left Arm

Tatiana A. _____ Nathalie K. _____ Dolenska T. _____ Valerie L. _____ Jackie D. _____ Amber I. _____ Marisol R. _____