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

Demographics

Name (Please print name neatly)

Last:	First:	Middle:
Gender: ☐ F ☐ M	Date of Birth: _____/_____/_____ (mm/dd/yyyy)	

Insurance Information (for new patient's)

Insurance Name:	Policy Number:	Group Number:	Claims Billing Address:

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

The Food and Drug Administration (FDA) has recently issued an Emergency Use Authorization for a COVID-19 vaccine. Sugarloaf Medical, P.C. is making this vaccine available to me and I have requested to receive the vaccine. I have received the FDA Fact Sheet on this vaccine, which informs me of the significant known and potential risks and benefits of emergency use of this vaccine.

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid, or other third parties who are financially responsible for my medical care. I authorize release of all information needed (included but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

I hereby consent to and authorize Sugarloaf Medical P.C., through its designated agents or representatives, to administer the vaccine as indicated below. 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 the results that may be obtained 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**