Pittsburgh Mercy COVID-19 Immunization
REGISTRATION, ACKNOWLEDGEMENT & CONSENT FORM

PITTSBURGH MERCY
A HERITAGE OF HOPE

Demographics (to be completed by colleague or person served)

Date: _____

Patient Name (last, first, middle): _____

Birth Date: _____ Sex: □ M □ F □ Nonbinary □ Unknown Marital Status: □ S □ M □ D □ W

Race (select one): □ White □ Black or African American □ American Indian/Alaskan □ Asian □Unknown
□ Native Hawaiian □Other Pacific Islander □Decline to answer

Ethnicity (select one): □ Not Hispanic/Latino □ Hispanic/Latino □ Unknown □ Decline to answer

Home Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone #: (home/cell)_____ Secondary #: (home/cell)_____+_____

Patient Email Address_____

Emergency Contact (last, first, middle): _____Relationship:_____

Primary Phone # _____ Secondary Phone # _____

Employer: _____ Occupation: _____

Employer's Phone # _____

PCP Name: _____ PCP Address: _____

PCP Phone # _____

Screening Questionnaire (to be completed by colleague or person served)

	YES	NO	DON'T KNOW
Are you feeling sick today? *Nausea, muscle ache, loss of taste or smell, nasal congestion, etc.*			
Do you have a fever (temp above 100.4 F or 38 C) today?			
Do you have allergies to medications, food, egg or latex? If "YES", list:			
Did you ever have a severe allergic reaction to something for which you required epinephrine or hospitalization?			
Have you ever had a severe allergic/ anaphylactic reaction to any vaccine?			
Have you ever received a COVID-19 vaccine? If yes, when and which manufacturer?			
If you were diagnosed with COVID-19 in the past 90 days did you receive antibody therapy or convalescent plasma for treatment of your COVID illness?			
Have you received another vaccine in the last 14 days?			
In the past two weeks, have you tested positive for COVID-19 or have you currently been exposed to someone with COVID-19?*(For healthcare personnel: have you had a high risk exposure for which you have been recommended to quarantine?)*			
Do you take any medication or have a medical condition that could weaken your immune system (HIV, cancer, etc.)? *If "YES", please note that you may have a reduced immune response to the vaccine.*			
Do you have a bleeding disorder or do you take a blood thinner?			
Are you or could you be pregnant? *Please note data are not available to inform vaccine-associated risks in pregnancy at this time.*			
Are you currently breastfeeding? *Please note that data are insufficient to assess the effect of COVID-19 vaccine on the breastfed infant at this time.*			

ACKNOWLEDGEMENT

I was provided the Fact Sheet for Recipients for the COVID 19 vaccine I am receiving. I read and/or had explained to me the information provided about the vaccine. I was given the chance to ask questions and any questions I had were answered to my satisfaction. I understand the risks and benefits of the vaccination and I am voluntarily choosing to get the vaccination.
I understand I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. If I have had a previous severe reaction to a vaccine, I will be monitored for 30 minutes. I understand if I experience any side effects after leaving the vaccination area, I should call my doctor, or if the side effects are severe, I should call 911.

Patient Signature: _____ Date: _____

DISCLOSURE OF RECORDS

I understand Pittsburgh Mercy may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated by Pittsburgh Mercy, my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state/federal registries, for purposes of treatment, payment or other health care operations. I also understand that Pittsburgh Mercy will use and disclose my health information as set forth in the ministry Notice of Privacy Practices (a copy is available upon request).
I agree that Pittsburgh Mercy and its business associates may contact me by any phone number provided by me or associated with my health record, including cell phone numbers, which could result in charges to me. Pittsburgh Mercy also may contact me by sending text messages or emails, using the contact information I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device.

Patient Signature: _____ Date: _____

Signature of Parent or Guardian _____Date: _____

Immunization Received (to be completed by pharmacist)

Informed Consent Provided	Yes
Injection Administered and Dose	Moderna COVID-19 Vaccine 0.5 ml
Date of Injection/Date provided with EUA	
Site of Administration	
Injection Manufacturer	Moderna
Injection Lot	
Injection Expiration Date	
Injection Administered By	
EAU Date	December 18, 2020
If applicable, nature of adverse reaction and name of PCP notified	