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

PITTSBURGH MERCY
A HERITAGE OF HOPE

First Name:	Last Name:		□ Male □ Female
Address:	City:	State:	Zip:
Phone			
Population/Occupation:	Birthdate:	Age:	
Race:	□ American Indian or Alaska Native	□ Asian	□ Black or African American
	□ Hawaiian or Other Pacific Islander	□ White	□ Unknown/Not Reported
Ethnicity:	□ Hispanic or Latino	□ Not Hispanic or Latino	□ Unknown/Not Reported
Primary Care Physician (PCP) First Name:		PCP Last Name:	
PCP Address			
PCP Phone:			

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

Indications: Please check "yes" or "no" for each question.	YES	NO	DON'T KNOW
Are you 18 years of age or older?			
Have you previously received a dose of COVID vaccine? If Yes: Which Vaccine □ Moderna □Pfizer □Johnson & Johnson Date(s) received: First Dose: Second Dose:			
If requesting a third dose of the Moderna COVID-19 vaccine: I have read and reviewed the CDC recommendations for moderately to severely immunocompromised and I attest that I am eligible for an additional dose of vaccine and meet the current requirements of the Centers for Disease Control and Prevention (CDC).			
Precautions and Contraindications: Please check "yes" or "no" for each	**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	