

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



**INSTRUCTIONS: Please complete and bring with you to your appointment.**

Date: \_\_\_\_\_

Patient Name (last, first, middle): \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex:  Male  Female  Nonbinary  Prefer not to answer 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 \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Phone # \_\_\_\_\_

Emergency Contact (last, first, middle): \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Phone # \_\_\_\_\_ Secondary Phone # \_\_\_\_\_

PCP Name: \_\_\_\_\_ PCP Address: \_\_\_\_\_

PCP Phone # \_\_\_\_\_

**SCREENING QUESTIONS**

	YES	NO	DON'T KNOW
1. Are you at least 18 years or older?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Are you sick today or do you have a fever?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Do you have allergies to any contents in this vaccine or to eggs or latex?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Have you ever had any allergic reaction (severe or immediate) to any vaccine?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Do you have a bleeding disorder or are you on a blood thinner?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Are you immunocompromised or on any medications that affect your immune system?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Have you received a COVID-19 vaccine previously? Manufacturer: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>8. Female patients:</b>			
a) Are you or could you be pregnant?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) Are you planning to become pregnant?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c) Are you breastfeeding?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. 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?)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Have you had any vaccinations in the past 14 days?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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**COVID-19 VACCINE ACKNOWLEDGEMENT**

I was provided the Fact Sheet for Recipients for the COVID-19 vaccine that I am receiving. I have read and/or had explained to me the information provided about the vaccine, and I attest that I meet the current CDC requirements for either a third dose or a booster dose. 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 that 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.

**AUTHORIZATION FOR PAYMENT**

I authorize release of my personal, billing and medical information to third party payers, insurance companies or review agencies for use in connection with payment, including eligibility for payment, regulatory or accreditation compliance or as is required for provider to receive payment or reimbursement for care. I authorize and irrevocably assign to the administrator of the vaccine payment of any benefits payable to me/amounts payable for the vaccine I receive.

**DISCLOSURE OF RECORDS**

I understand Pittsburgh Mercy may be required to, or may voluntarily disclose, my health information to: the physician responsible for the protocol 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 Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Parent or Guardian:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Immunization Received (to be completed by vaccinator)**

<b>Informed Consent Provided</b>	YES
<b>Injection Administered</b>	Moderna COVID-19 Vaccine
<b>Dose</b>	<input type="checkbox"/> 0.25 ml <input type="checkbox"/> 0.5 ml
<b>Date of Injection/Date provided with EUA</b>	
<b>Site of Administration</b>	
<b>Injection Manufacturer</b>	Moderna
<b>Injection Lot</b>	
<b>Injection Expiration Date</b>	
<b>Injection Administered By</b>	
<b>EUA Date</b>	January 7, 2022
<b>If applicable, nature of adverse reaction and name of PCP notified</b>	