|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Last Name | | First Name | | | M.I. | Gender |
| Last 4 Digits of Social Security Number | | Date of Birth | | | Age Race | Race |
| Street Address | | | Phone | | | |
| City | County | | | State | | Zip |

# PARENT / LEGAL GUARDIAN INFORMATION FOR DEPENDENTS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Last Name | First Name | | Relationship to Patient   * Parent ☐ Legal Guardian ☐ Other | | |
| Street Address if Different | | City | | State | Zip |
| Phone | | Emergency Contact | | | |

INSURANCE INFORMATION

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Insurance Carrier | | ID | BIN | PCN | |
| Group | Cardholder Name | | Cardholder Date of Birth | |
| Relationship to Patient Self ☐ Parent ☐ Legal Guardian ☐ Spouse ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

# VACCINATION AND HEALTH-RELATED INFORMATION

|  |  |  |
| --- | --- | --- |
| Has the patient ever received a COVID-19 vaccination? If yes, date given Manufacturer | * Yes | * No |
| Does the patient have long-term health problems with: •immunocompromised condition or taking a medicine that affects your immune system?  (Heart Disease • Lung Disease • Asthma • Kidney or Liver Disease • Metabolic Disease, such as Diabetes • Bleeding disorder or take a blood thinner) | * Yes | * No |
| Has the patient had life threatening reaction to any injectable medication, including a COVID-19 vaccine, or to a vaccine component (examples: eggs,  thimerosal, gelatin, neomycin, phenol, or bovine protein)? Yes, list | * Yes | * No |
| For Women: Are you pregnant or considering becoming pregnant in the next three months, or currently nursing? | * Yes | * No |
| Has the patient had a seizure or any other brain or other nervous system problem (i.e., Guillain-Barré Syndrome) after receiving a vaccine? | * Yes | * No |

I have read the Emergency Use Authorization (EUA) Fact Sheet or the VIS about the COVID-19 virus and vaccine. I understand the benefits and risks of the COVID-19 vaccine. I give permission for the above-named patient to receive the vaccine indicated. I authorize billing insurance for the vaccine administration fee for the vaccine provided. I have also received notice of my privacy rights, and I have been given or offered a copy of the ***SCDHEC “Notice of Privacy Practices.***” I understand this information is available upon request, as well as available for review at the time of vaccination.

Signature or Signature of Representative (Power of Attorney) Date

(To Be Completed by Vaccine Administrator)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date Vaccine and VIS Given | VIS or EUA Fact Sheet Date (circle one) | | | Clinical Site | | County Code | | | NCES # | |
| Vaccine Given: ☐ Jansen | | | | | | | | | | |
| Manufacturer | | Lot Number | NDC # | | Expiration Date | | | Site of Injection:  LA RA | | Route IM |
| Pharmacist Signature | | | | | | | Date | | | |

# COVID-19 Vaccine Form 12/15/2020

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_