



Immunization Adult Health History-COVID- 3rd DOSE

Today's Date: _____

Name: First _____ Last _____ MI _____

Address _____ City _____ State _____

Zip Code _____ County _____ Sex (circle) M F Birth Date _____ Age _____

Phone Number _____

Race: Asian/Pacific Islander Black Native Am/Alaskan Native White Other

Ethnicity: Hispanic Non-Hispanic

1. Are you sick today? If yes, please list symptoms Yes _____ No _____

2. Do you have any drug allergies? List on line below: Yes _____ No _____

3. Have you ever had a serious reaction after receiving a vaccine? If yes, which vaccine? Yes _____ No _____

4. Please circle the type of vaccine you previously received **Pfizer** **Moderna** **Johnson and Johnson (Janssen)**

5. Dates of previous doses of COVID-19 vaccine? ___/___/___ ___/___/___

6. Have you had any vaccinations in the past 14 days? If yes, which vaccination? Yes _____ No _____

I have received a copy of the Emergency Use Authorization Fact Sheet(s) regarding the disease and vaccine and understand there is a risk of slight to severe reaction with any vaccination. I also understand that this is a less risk than the risk to an unvaccinated person who could acquire this disease. By signing this form, I also acknowledge that I have received a copy of Massillon City Health Department's Notice of Privacy Practices. I also grant permission for this record to be released to medical providers, health departments and to transmit to the immunization registry.

Patient/Guardian Signature: _____ Date: _____

Printed Name _____

*******FOR OFFICE USE ONLY*******

Form Reviewed by: _____ Date _____

Manufacturer:

Next Appointment: _____

Lot #:

Site: Left Arm Right Arm

Vaccinator _____