Massillon
City of Champions
Health Department

Immunization Health History-COVID

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

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

_____

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

   _____

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

   _____

3. Have you ever had a previous dose of any COVID-19 vaccine? If yes, which vaccine and when Yes _____ No _____

   _____

4. 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_____