Immunization Adult Health History-COVID-19 Vaccine

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. Have you ever had a previous dose of any COVID-19 vaccine? Yes _____ No _____

   a. **If YES** please circle the type of vaccine you previously received: **Pfizer Moderna Johnson and Johnson**

   b. Dates of previous doses of Covid-19 vaccine? ___/___/___ ___/___/___ ___/___/___ ___/___/___

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_____ _____