BeverlyCare

COVID-19 VACCINATION PROGRAM REGISTRATION FORM

First Name:	Last Name:		DOB:
Home Address:	City:	State:	Zip Code:
Cell Phone: (in order to text you for 2nd dose appointment)	Email: (in order to email you for 2nd dose appointment)		
Sex: ( ) Male ( ) Female	Race:	Ethnicity:	
Insurance: ( ) Yes ( ) No	Insurance Type: ( ) Medi-cal ( ) Medicare ( ) Commercial ( ) Other _____		
Insurance Name:	Insurance Policy#:	Insurance Policy Group or Workforce #:	
Are you the primary policy holder: ( ) Yes ( ) No	If not, please name:		
Appointment made at: ( ) www.beverlycare.org ( ) www.myturn.ca.gov ( ) Other _____			

VACCINATION CONSENT

Disclosure Statement: Life threatening allergic reactions to vaccines are very rare. Signs of a serious allergic reaction include: shortness of breath, hoarseness of wheezing, hives, paleness, weakness, elevated heart rate, or severe dizziness. These symptoms may occur within a few minutes, or up to 48 hours after the vaccination. If you are experiencing any of these symptoms, you should contact a healthcare provider immediately.

( ) VERBAL CONSENT: The patient or legal guardian has been provided with the benefits and potential adverse reactions information, and provides consent to receive the vaccine today, OR

WRITTEN CONSENT: Signature_____ Date: _____ I understand the benefits and potential adverse reactions of the COVID-19 vaccine and consent being vaccinated today.

VACCINATION (To be completed by BeverlyCare Personnel)

Today's Date:	Dose: ( ) 1st dose ( ) 2nd dose	Brand: ( ) Moderna ( ) Pfizer ( ) Janssen	
Vaccine Administrator:	Arm: ( ) Left ( ) Right	Lot#:	
Reactions:			
Next Appointment: ( ) Not applicable ( ) 2nd dose: _____			

VACCINATION QUESTIONNAIRE

*Are you feeling sick today?
( ) YES ( ) No

*Have you ever received a dose of COVID-19 vaccine?
( ) YES ( ) No

*Have you ever had an allergic reaction to (1) component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures, (2) Polysorbate, (3) a previous dose of COVID-19 vaccine (This would include a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)
( ) YES ( ) No

*Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)
( ) YES ( ) No

*Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of the COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.
( ) YES ( ) No

*Have you been diagnosed with MultiSystem Inflammatory Syndrome (MISC-C or MIS-A) after a COVID-19 infection?
( ) YES ( ) No

* Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?
( ) YES ( ) No

*Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?
( ) YES ( ) No

*Do you have a bleeding disorder or are you taking a blood thinner?
( ) YES ( ) No

*Do you have a history of heparin-induced thrombocytopenia (HIT)?
( ) YES ( ) No

*Are you pregnant or breastfeeding?
( ) YES ( ) No

*Have you received dermal fillers?
( ) YES ( ) No

*Do you have a history of myocarditis or pericarditis?
( ) YES ( ) No

Interviewed by: _____ Date: _____

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