

Patient Information (Please Print)			
Name:		Date of Birth/Age:	Phone #:
Home Address:			SS# or DL#
City:	State:	Zip:	County:
Gender:	Race:	Ethnicity: Hispanic/Latino or Not Hispanic/Latino	
Do you live within Mount Vernon city limits? Yes No			
Insurance Information			
Medicare Plan/Number:		Medicaid Plan/Number:	
Private Insurance Company Name:			
Member ID#		Group #	
Insured Name/DOB:		Relationship to Insured:	

Please answer the following questions		
1. Are you sick today?	YES	NO
2. Have you ever had a serious (anaphylactic) reaction after receiving a vaccination?	YES	NO
3. Are you taking any medications that lower the body's resistance to infection?	YES	NO
4. Females Only: Are you currently pregnant or breastfeeding?	YES	NO
5. Have you received any vaccines in the past two weeks?	YES	NO
6. Have you received any previous doses of mRNA COVID 19 vaccine (Pfizer or Moderna)?	YES	NO
7. If yes, how many doses? (please circle) Pfizer 1 2 3 4+ Moderna 1 2 3 4+		

The Knox Public Health or Health Center may keep this record in your medical file. They will record what vaccine was given, date the vaccine was given, the name of the company that made the vaccine, the vaccine special lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given. I understand that this information will be released to a state-wide Immunization Registry for the purpose of immunization tracking recall and recording, unless I request otherwise. I have read or have had explained to me the Vaccine Information Sheet about COVID-19 disease and the COVID-19 vaccine. I have had a chance to ask questions, and they were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to the person named above for whom I am authorized to make this request. Your medical information is never shared without an authorization to release information. A copy of Knox Public Health's Notice of Privacy Practices (HIPAA) will be provided upon request, and it is also located on our website at www.knoxhealth.com.

Patient/Guardian Signature: _____ Date: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY

COVID-19 Vaccine ___ VFC ___ 317 ___ Prvt ___ Bridge ___ E-clinical	Injection Site: IM ___ RD ___ LD ___ RVL ___ LVL	Vaccine Manufacturer: _____ Lot # _____ Expiration: _____	Vaccine Administrator Signature: _____ Date _____
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