

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 a dose of COVID 19 vaccine? a. If yes, which vaccine ___ Pfizer ___ Moderna ___ Janssen (J&J)?	YES	NO
7. If receiving the Moderna Vaccine today, are you immunocompromised? a. If yes, how many doses have you received? ___1 ___2	YES	NO
8. Have you received passive antibody therapy as treatment for COVID-19 in the past 90 days? *If yes, we recommend waiting to get your vaccine until 90 days is complete.	YES	NO

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: _____

(Initial)

_____ I choose not to wait 15 minutes after the second, third, or booster dose of COVID-19 vaccine.

_____ I accept responsibility for that decision and waive all liability for Knox Public Health.

FOR OFFICE USE ONLY

COVID-19 Vaccine ___ E-clinical ___ ImpactSIIS	Injection Site: IM ___ Right Deltoid ___ Left Deltoid	Vaccine Manufacturer: _____ Lot # _____ Expiration: _____ Dose, if Moderna: 0.25mL or 0.5mL	Vaccine Administrator Signature: _____ Date _____
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