Utah County
HEART of UTAH
Health Department

COVID Immunization Encounter Form

Patient Name: _____ **Birthdate:** ___ /___ /_____ **Age:** _____

Address: _____ **#:** ____ **City:** _____ **State:** ____ **Zip:** _____

Phone #: (_____) _____ - _____ **Email:** _____ **Gender:** ☐ Male ☐ Female

Race (Circle): ☐ African American, ☐ Alaska Native, ☐ Asian/Pacific Islander, ☐ Native American, ☐ White, ☐ Other

Check box: Ethnicity: Hispanic ☐ Yes ☐ No

Please answer these questions concerning the individual receiving immunizations today by checking the boxes	**Yes**	**No**
Are you moderately to severely sick and/or have you had a fever within the last 24 hours?	☐	☐
Do you have allergies to medications, food, latex, or any vaccine?	☐	☐
Have you had a serious allergic reaction in the past (anaphylaxis)?	☐	☐
Have you ever had an allergic reaction (of any severity) to mRNA COVID-19 vaccine or any of its components including polyethylene glycol (PEG) or polysorbate?	☐	☐
Do you carry an Epi-pen?	☐	☐
Have you been treated for COVID disease with Monoclonal antibodies/Convalescent plasma in the last 90 days?	☐	☐
Have you been diagnosed with MIS-C or MIS-A in the last 90 days?(Multisystem Inflammatory Syndrome)	☐	☐
Have you been injected with any cosmetic/dermal fillers?	☐	☐
If you are female, are you pregnant or breastfeeding?	☐	☐
HAVE YOU RECEIVED A PREVIOUS DOSE OF COVID-19 VACCINE? Mfg and DATE:	☐	☐
Are you under the age of 18? If yes, what is your age?	☐	☐
Are you below age 18 taking aspirin therapy?	☐	☐
Do you have a history of immune-mediated blood clots associated with low platelets such as HIT (Heparin-induced thrombocytopenia?) **(ONLY PERTAINING TO J&J VACCINE)**	☐	☐

I have been given a copy and have read or had explained to me, the information contained in the EUA Fact Sheet about the disease(s) and vaccine(s). Any questions I had were answered to my satisfaction. I understand the benefits and risk of the vaccine(s) and request that the vaccine(s) indicated be given to me or the person for whom I am authorized to make this request. I certify that I have received a copy or been given the opportunity to read the **Notice of Privacy Practices**. I agree that the immunizations may be shared with schools, day care centers, health care providers, and others to verify immunization status, for public health studies, or when medically necessary. I hereby release the Utah County Government and their employees from all claims arising from such immunizations.

JURISDICTION AND VENUE The terms and conditions contained within this agreement shall be governed by the laws of the State of Utah and shall be construed and interpreted in accordance with those laws. Any action or proceeding brought by either party which is based upon or derived from, or in any way related to this agreement shall be brought in a court of competent jurisdiction within the state of Utah. The parties hereto consent to their personal jurisdiction of said court.

If patient is under age 18, parent or guardian must sign below. If you are age 18 or over, sign below for yourself:

Authorization Signature: _____ Date: ___/___/_____

If Signature above IS **NOT** the patient's, Print Your Name: _____ DOB: ___ / ___/ _____

Relationship to patient if not self:_____

Date printed on EUA Vaccine Fact Sheet: Pfizer: August 2021, Moderna: December 2020

BELOW FOR OFFICE USE ONLY

COVID-19	**Category**	**Site**	**Lot #**	**Dose**	**Date of Service:** _____ /_____ /_____
Moderna Dose #1	State			0.5	**NOTES:**
Moderna Dose #2	State			0.5	
Pfizer Dose #1	State			0.3	
Pfizer Dose #2	State			0.3	
Booster Dose P M	State			0.3/0.5	**AF** **OFF** **PAY** **PRO**

Counselor: Vaccinator: ☐ Wait 15 minutes Time:

Employee # or initials as completed	**U**	**R**	**N**	**C**	**S**