PHC PARTNERSHIP HEALTH CENTER

Please have this form filled out and with you for your appointment.

2nd Dose Intake Form

Appointment date: _____ **Appointment time:** _____

(circle one) Which vaccine are you here for today? Pfizer / Moderna / Johnson & Johnson

Patient Name (please print legibly) _____

Date of Birth _____

YES	NO	
○	○	Are you feeling ill or do you have a fever today?
○	○	Did you have an allergic reaction to the first dose of the COVID-19 Vaccine?
○	○	Have you received a vaccine of any kind within the past 14 days (i.e. the flu shot?)
○	○	Are you pregnant or breastfeeding?
○	○	Did you answer yes to any of these questions?

I understand I will need to stay for at least 15 minutes after injection for monitoring: **YES** **NO**

I authorize my health care provider and a public health agency to collect and enter my immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my medical care and treatment. In addition, information may be released to schools in order to comply with immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department. **YES** **NO**

Patient Signature _____ Date: _____

This section to be completed by the person administering the vaccine:

(Circle One) Injection Site: Left Deltoid IM Right Deltoid IM

Time of Administration: _____ **Dose 2**