Patient Information Sheet
Covid 19 Vaccine
Bear River Health Department

Patient Information (Please Print Legibly)

Patient Name: ____

Patient Birthdate: ________________________ Patient Age ____________________________

Patient Drivers License Number: ____________________________________

Patient Sex: ☐ Male ☐ Female

Email: ____

Patient Address:____

City: ________________________ State: __________ Zip Code:__________

Patient Phone Number: ______________________________

(Required) Patient Race:

☐ White ☐ Black/African American ☐ Chinese ☐ Japanese ☐ Asian Indian

☐ Korean ☐ Vietnamese ☐ Filipino ☐ Other Asian ☐ Native Hawaiian

☐ Samoan ☐ Tongan ☐ Guamanian ☐ Other Pacific Islander ☐ Other Race

☐ American Indian or Alaskan Native

(Required) Ethnicity:

☐ Hispanic Descent
☐ Not of Hispanic Descent
☐ Unknown

Do you have health insurance? ☐ **Yes** ☐ **No**

Insurance Information: (Please Print)

Please have card ready

Insurance Company: ____

Policy Holder Name: ________________________ **Policy Holder** Birthdate:________________

Policy or **Subscriber Id#**: ____________________**Policy Holder** Relation to Patient:__________

PLEASE TURN OVER TO COMPLETE

Is this your first, second, or third dose of Covid vaccine? ☐ 1st ☐ 2nd ☐ 3rd

*If it is your 2nd dose, what brand was your first dose? ☐ Pfizer ☐ Moderna ☐ J&J

Has the patient had a severe allergic reaction to any vaccination? ☐ Yes ☐ No

Please ask the clinic staff if you would like a copy of the vaccine information sheet. If not, please acknowledge that it was offered. ☐ Yes

Do you understand the recommendation to wait 15 minutes for any adverse reactions? ☐ Yes ☐ No

HIPAA

I acknowledge receipt of a copy of the Bear River Health Department (Health Department) Notice of Privacy Practices-For Protected Health Information (Notice) which I have or will carefully review, and acknowledge my rights for a more complete description and understanding of potential uses, disclosures of and/or requests for such Protected Health Information by the Health Department.

I acknowledge that the Health Department reserves for itself the right to change the terms of its Notice at any time, and that if the Health Department does not change the terms of its Notice, I acknowledge the right to obtain a copy of the current revised Notice at any Health Department office.

X____

Signature of Client (or Parent/Guardian/Representative) Date

Consent for Services:

I have been provided with information about the vaccine I am receiving today. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine.

X____

Signature of Client (or Parent/Guardian/Representative) Date

For Office Use Only:

Lot Number:__________________ Site:________ Dose: 1st 2nd 3rd Nurse Initials:________