Please complete the following information for the person receiving the COVID-19 vaccine.

PATIENT DEMOGRAPHIC INFORMATION

*Last Name:		*First Name:		Middle Initial:	
*Date of Birth / /		*Sex: Male ☐ Female ☐ Transgender ☐ Other ☐			
*Race White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ None Specified ☐ Refused ☐				Hispanic Ethnicity: Yes ☐ No ☐ Unknown ☐ Refused ☐	
Address:				City:	
State:	Zip:	County:	Home Phone:	Cell Phone:	
☐ Private or employer insurance		☐ Underinsured	☐ Uninsured	☐ Medicare	☐ Medicaid
Primary Care Physician:		PCP Address:		Phone:	Fax:

	HEALTH HISTORY	YES	NO	UNKNOWN
1.	Are you feeling sick today?	☐	☐	☐
2.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? *****Please notify someone immediately if you are allergic to polyethylene glycol or polysorbate***** For example, a reaction for which you were treated with epinephrine or Epi Pen or for which you had to go to the hospital?	☐	☐	☐
3.	Have you ever had a serious reaction after any vaccination or injectable medication including a previous dose of the COVID-19 vaccine?	☐	☐	☐
4.	In the past 14 days have you had contact with a confirmed COVID-19 patient	☐	☐	☐
5.	Are you breastfeeding or pregnant?	☐	☐	☐
6.	Have you received passive antibody therapy as a treatment for COVID-19	☐	☐	☐
7.	Are you immunocompromised? *(taking medication or being treated for cancer, leukemia, HIV/AIDS or other immune system problems or taking medication that affects your immune system)*	☐	☐	☐
8.	Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
9.	Have you ever received a dose of COVID-19 vaccine? If so, Date received_________.	☐	☐	☐
10.	Have you received any vaccinations in the past 14 days?	☐	☐	☐

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV–2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the CICP and filing a claim is available by calling 1-855-266-2427 or visiting https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine or https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/moderna-covid-19-vaccine

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that I have received or have been advised of the Missouri Department of Health and Senior Services' Notice of Privacy Practices and where I can obtain any revisions made to this Notice.

_________ (initial) I understand that I must wait 15 minutes after my vaccination for observation for any adverse events. If I have had a previous anaphylactic reaction for any reason, I understand I must wait for 30 minutes.

PLEASE PRINT NAME of signature below

SIGNATURE OF PATIENT OR GUARDIAN	RELATIONSHIP TO CLIENT	TODAY'S DATE

For Clinic Use only

<table>
<tr><td>Manufacturer</td><td>Brand</td><td>Lot number</td></tr>
<tr><td>Dose number 1☐ or 2☐</td><td>*Exp. Date: ___ /___ /___</td><td>Vaccine Dose ________________</td></tr>
<tr><td rowspan="2">*EUA fact sheet date: ___ /___ /___</td><td rowspan="2">Date administered and EUA fact sheet given date: ___ /___ /___</td><td>Injection Site (Deltoid) L ☐ R ☐</td></tr>
<tr><td></td></tr>
<tr><td colspan="3">*Administered by Name & Title :</td></tr>
<tr><td colspan="3">*Agency: Ozarks Healthcare Pharmacy</td></tr>
<tr><td colspan="3">*Agency Address: #18 Parkway Center West Plains MO 65775</td></tr>
<tr><td colspan="3">*Clinic administration address: same</td></tr>
<tr><td colspan="3"></td></tr>
</table>

INSURANCE INFORMATION:

<table>
<tr><td>BIN</td><td>PCN</td><td>ID</td><td>Group</td></tr>
<tr><td colspan="2">Medicare or Medicaid ID</td><td>2nd appointment date:</td><td>Time:</td></tr>
</table>