PassportHealth

# COVID-19 Worksheet

*Please fill this form out completely*

| Last Name | First Name | Middle Initial | Date of Birth | Age: | Gender: ☐ Female ☐Male |
|---|---|---|---|---|---|

| Street Address | City | State | Zip Code | Mothers Name |
|---|---|---|---|---|

| Phone Number ☐ Cell ☐ Home | Social Security # Last 4 digits | Ethnicity: Hispanic Origin ☐ Yes ☐ No | Race: ☐ American Indian/Alaskan Native ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Asian ☐ White |
|---|---|---|---|

| Email Address: | Have you ever received a dose of COVID-19 vaccine? ☐ Yes ☐ No If yes, which vaccine did you receive? |
|---|---|

**Does patient have medical health insurance** ☐ Yes ☐No If yes, please complete questions below or bring a PRINTED copy of the card with you to clinic.

| ☐ **Medicaid** | Medicaid Number: | First and Last name as it appears on card | Medicaid Plan Name: | |
|---|---|---|---|---|
| ☐ **Private Insurance** | Indicate Primary insurance: | Policy Holder: | Group No.: | ID #.: |
| Policy Holder DOB: | Indicate Secondary insurance: | Policy Holder: | Group No.: | ID#.: |
| ☐ **Medicare** | Do you have Medicare Part B: ☐ Yes ☐ No | Is Medicare Primary? ☐ Yes ☐ No | Medicare Number: | |

## Medical Screening

1. Do you have a fever (>100F), infection or current illness today? Yes No
2. Have you ever had a significant allergic reaction to a vaccine or other injection? Yes No
3. Are you pregnant, plan to be pregnant or currently breastfeeding? Yes No
4. Have you received passive antibody therapy as treatment for COVID-19? Yes No
5. Do you have a severely immunocompromising condition? Yes No
6. Do you have a bleeding disorder or are you taking a blood thinner? Yes No
7. Do you have an allergy to a component of the vaccine? Yes No
8. Have you received another vaccine in the last 14 days? Yes No

Consent: I, the undersigned, give my consent for the services that I am requesting from Passport Health and its entities/contractors. I acknowledge that I received the Vaccine Manufacturer COVID-19 Fact Sheet for Recipients and Caregivers prior to receiving the vaccine and have had the opportunity to ask questions.
I understand the benefits and risks of the vaccine and request it be administered to me or the person for whom I am authorized to make consent. I may request the Notice of Health Information Practices (HIPAA) and I authorize my immunization record to be recorded with the State Vaccine Registry and released to employer, school, and/or physician if requested.

**Patient Signature:**______________________________ **Date:** ____________________

**Office use only**

| ________ Date / Time | COVID Vaccine Vaccine | Moderna, Pfizer, JNJ Vaccine Manufacturer | ________ Lot Number | ________ Exp. Date | RA \| LA Deltoid injection site |
|---|---|---|---|---|---|

| Pfizer (Circle one) | 1st | 2nd | booster | Booster2 |
|---|---|---|---|---|
| Moderna (Circle one) | 1st | 2nd | booster | Booster2 |
| Janssen Circle one) | 1st | | booster | Booster 2 |
| Pfizer Peds 5-11 | 1st | 2nd | booster | |

**Nurse/Vaccine Administrator:** ______________________________

PassportHealth

# COVID-19 Worksheet

*Complete su formulario entero, por favor*

| Apellido | Primer nombre | Inicial | Fecha de nacimiento | Edad: | Género: □ Mujer □ Hombre |
|---|---|---|---|---|---|

| Dirección | Ciudad | Estado | Código postal | Nombre de Mama |
|---|---|---|---|---|

| Numer de Telefono ( ) - □ Cell □ Home | Ultimo 4 digitos de su seguro | Etnicidad: Hispanic Origin ☐ Yes ☐ No | Race: □ American Indian/Alaskan Native □ Black/African American □ Native Hawaiian/Other Pacific Islander □ Asian □ White |
|---|---|---|---|

| Correo electrónico: | ¿Ha recibido alguna vez una dosis de la vacuna COVID-19? Si No |
|---|---|

¿El paciente tiene seguro médico? ☐ Yes ☐ No Si es así, por favor complete las preguntas a continuación o traiga una copia IMPRESA de la tarjeta con usted a la clínica..

| ☐ Medicaid | Medicaid Number: | First and Last name as it appears on card | Medicaid Plan Name: | |
|---|---|---|---|---|
| ☐ Private Insurance | Indicate Primary insurance: | Policy Holder: | Group No.: | ID #.: |
| Policy Holder DOB: | Indicate Secondary insurance: | Policy Holder: | Group No.: | ID#.: |
| ☐ Medicare | Do you have Medicare Part B: ☐ Yes ☐ No | Is Medicare Primary? ☐ Yes ☐ No | Medicare Number: | |

## Medical Screening

1. ¿Tiene fiebre (> 100F), infección o enfermedad actual hoy? SI No
2. ¿Ha tenido alguna vez una reacción alérgica significativa a una vacuna u otra inyección? SI No
3. ¿Está embarazada, planea estarlo o está amamantando actualmente? SI No
4. ¿Ha recibido terapia con anticuerpos pasivos como tratamiento para COVID-19? SI No
5. ¿Tiene una enfermedad inmunodeprimida grave? SI No
6. ¿Tiene un trastorno hemorrágico o está tomando un anticoagulante? SI No
7. ¿Tiene alergia a algún componente de la vacuna? SI No
8. ¿Ha recibido otra vacuna en los últimos 14 días? SI No

**Consent:** Yo, el abajo firmante, doy mi consentimiento para los servicios que solicito a Passport Health y sus entidades / contratistas. Reconozco que recibí la Hoja informativa del fabricante de vacunas COVID-19 para beneficiarios y cuidadores antes de recibir la vacuna y he tenido la oportunidad de responder preguntas.
Entiendo los beneficios y riesgos de la vacuna y solicito que me la administren a mí oa la persona para quien estoy autorizado a dar mi consentimiento. Puedo solicitar el Aviso de Prácticas de Información de Salud (HIPAA) y autorizo que mi registro de inmunización se registre en el Registro de Vacunas Estatales y se entregue al empleador, la escuela y / o el médico si así lo solicita.

**Firma del paciente:** ______________________________ **Fecha** ____________________

**Office use only**

| ____________ | COVID Vaccine | Moderna, Pfizer, JNJ | ________ | ________ | RA \| LA Deltoid |
|---|---|---|---|---|---|
| Date / Time | Vaccine | Vaccine Manufacturer | Lot Number | Exp. Date | injection site |

**Nurse/Vaccine Administrator:** ______________________________

| Pfizer (Circle one) | 1st | 2nd | booster | Booster2 |
|---|---|---|---|---|
| Moderna (Circle one) | 1st | 2nd | booster | Booster2 |
| Janssen Circle one) | 1st | | booster | Booster 2 |
| Pfizer Peds 5-11 | 1st | 2nd | booster | |