Form Date: 2/2021

Missoula City-County Health Department
COVID-19 RESPONSE
301 W Alder Street| Missoula, MT 59802-4123
PHONE | 406.258.INFO
scheduling@missoulacounty.us

Date: Appointment Time: _____

REGISTRATION FORM: (please print)

Client Name

Date of Birth **Sex at Birth**

Mailing Address:

City **County:** **State:** **Zip Code:**

Phone

2nd Dose Scheduled: _____

Ethnicity: (circle one): Hispanic/Latino Not Hispanic/Latino Declined

Race: (circle one):
White Black/African American
American Indian/Native American
Asian Native Hawaiian/Pacific Islander
Other Decline

Email

Arrival Time _____

Acknowledgement and Consent: Please check each of the following boxes

1. ☐ **Consent to treat**: I authorize Missoula City-County Health Department to administer treatment as deemed necessary for care of the patient named above. If applicable, I certify that I am the parent or legal guardian of the patient. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.
2. ☐ **Assignment of Benefits**: I authorize payment of medical benefits to Missoula City-County Health Department for services rendered.
3. ☐ **Privacy Notice:** I have reviewed a copy the Notice of Privacy Practices, which provides a description of information uses and disclosures. I may request a copy of the Notice of Privacy Practices for my own records.
4. ☐ **ACCEPT imMTrax State Immunization Registry** ☐ **DECLINE imMTrax State Immunization Registry**

(Please read the following statement and check ***Accept*** or ***Decline*****):** I authorize my health care provider and local public health agency to collect and enter my or my child's immunization records into the Department of Public Health and Human Services' immunization registry (imMTrax), a confidential computer system that contains immunization records. I understand that information in the registry may be released to local health departments, as well as my health care providers to assist in my or my child's medical care and treatment. In addition, information may be released to childcare facilities and schools in which my child is enrolled to comply with state requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department.

Safety Acknowledgement and Waiver:

1. ☐ **EUA COVID-19 Fact Sheet:** I have read or have had explained to me the information contained in the Fact Sheet about the disease and the vaccine.
2. ☐ **Authorization:** I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine to be administered today to me or to the person named above for whom I am authorized to make this request.
3. ☐ I understand that I must wait the full 15-30 minutes depending on my risk factors. This is a safety precaution to avoid possible problems associated with fainting or an allergic reaction.

Client (Parent/Guardian) Signature: _____ **Date:** _____
By signing this form, I agree that the information I provided is accurate and truthful and I agree with the acknowledgement and consent above.

Start Time_____

Finish Time: _____

Office use only:

☐ **No contraindications or precautions to vaccinations.**

Lot #_____ **Location: R-Deltoid L-Deltoid Manufacturer**_____

Dose 1: _____ **Dose 2:** _____

Reviewed by/ RN signature:_____ **Date:**_____

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name _____

Age _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.
If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked.
If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Another product _____			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
• Polysorbate	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	☐	☐	☐
6. Have you received any vaccine in the last 14 days?	☐	☐	☐
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
11. Are you pregnant or breastfeeding?	☐	☐	☐

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists