Date:_____

FAMILY MEDICAL SERVICES, INC.

COVID-19 Vaccine Registration Form
All Fields Required

First Name:_____ **Middle Initial**_____ **Last Name**:_____

Gender: Male:___ Female: ___ **Date of Birth**:_____ **Employer:**_____

Ethnicity:

_____Hispanic or Latino

_____None Specified

_____Not Hispanic or Latino

Race:

_____White

_____Black or African American

_____American Indian or Alaskan Native

_____Native Hawaiian or Pacific Islander

_____Unknown

_____Other

Patient Home Street Address: _____

City:_____ **State:** _____ **Zip**:_____

INSURANCE INFORMATION: Do you have insurance? Yes_____ No_____

Social Security Number: _____ *Red, White and Blue Medicare #* (if applicable):_____

AL Medicaid # (if applicable): _____

Please list medical and drug insurance card information in the box below:

MEDICAL Insurance Company Name	Contract/ Member ID #	Group #	Relationship to cardholder
_____	_____	_____	**Self, Spouse or Child**

DRUG Insurance Company Name:_____ Relationship to cardholder

BIN #:_____PCN#:_____ **Self, Spouse or Child**

Contract/ Member ID#:_____ RX Group#:_____

Patient Phone Number: _____ Cell_____ Home_____ Work_____

Family Medical Services, Inc.

Version 1
2.8.21

COVID-19 Vaccine Consent

☐ First Dose ☐ Second Dose

Type of vaccine for first dose: ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) Date first dose received: _____

Name:_____ Date:_____ Date of Birth:_____

Address:_____

Email:_____ Phone Number:_____

Facility/Organization where you primarily work:_____ History of anaphylactic reaction? Y or N

If you had a severe allergic reaction to the first dose, tell your vaccine administrator and **DO NOT TAKE THE SECOND DOSE.**

EEO: ☐White ☐Asian ☐Hispanic/Latino ☐Black/African American ☐American Indian/Alaskan Native
☐Native Hawaiian/Pacific Islander ☐Two or More Races Gender: ☐Male ☐Female ☐Other

EEO tracking information is required by states and will not be used for any other purposes

Coronavirus disease 2019 (COVID-19) is an infectious disease caused by the novel coronavirus, SARS-CoV-2, that appeared in late 2019. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have reported a wide range of symptoms, ranging from mild symptoms to severe illness.

Symptoms may appear 2 to 14 days after exposure to the virus. Symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

You should not get this vaccine if you:

- had a severe allergic reaction after a previous dose of this vaccine
- had a severe allergic reaction to any ingredient of this vaccine
- are under 18 years of age, as the Moderna COVID-19 vaccine is only indicated for individuals 18 years of age or older.

Talk to your doctor about whether you should receive the COVID-19 vaccine if you have any of the following:

- have any allergies
- have a fever
- have a bleeding disorder or are on a blood thinner
- are immunocompromised or are on a medicine that affects your immune system
- are pregnant or plan to become pregnant
- are breastfeeding
- have received another COVID-19 vaccine

Serious, unexpected and unknown adverse events could occur from receiving the COVID-19 vaccine. The EUA states that side effects that have been reported include: injection site pain, tiredness, headache, muscle pain, chills, joint pain, fever, injection site swelling, injection site redness, nausea, feeling unwell, and swollen lymph nodes (lymphadenopathy). There is a remote chance that the COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the COVID-19 Vaccine.

If after vaccination you experience any complications that may be related to the COVID-19 vaccine, contact your doctor and vaccine administrator for potential reporting.

- I have read and understand this COVID-19 vaccine consent form.
- I have received, read, and understand the Emergency Use Authorization Fact Sheet for Recipients.
- I have had the opportunity to discuss any concerns with my doctor.
- The administration of the vaccine does not create a patient provider relationship between administrator and recipient.
- **I** understand the risks and benefits of the COVID-19 vaccine.
- I am 18 years of age or older.
- I did not have a severe allergic reaction after a previous dose of any COVID-19 vaccine.
- I do not have a severe allergy to any part of this vaccine.
- I understand that my information and vaccination status will be reported to the state.
- I freely and voluntarily request to receive the COVID-19 vaccine.

Patient Signature or Legal Guardian Signature: _____ Date:_____

OFFICE USE ONLY BELOW

Manufacturer _____ Lot # _____ Exp. Date _____

Route IM **(circle one)** Left deltoid Right deltoid Date/Time Vaccine Given _____

Printed Name of Vaccine Administrator _____

Provider #: 051558502

Date uploaded to ImmPRINT_____
ImmPRINT data enterer Name_____

0040204062 Vaccine info sheet to be completed by patient Date: ___/___/_____

◯ First Dose ◯ Second Dose

Please fill in circles completely

What is your age group (in years)? ◯ Under 16 ◯ 16-17 ◯ 18-30 ◯ 31-64 ◯ 65-75 ◯ 75-85 ◯ Over 85

What is your race and ethnicity (Select ALL that apply)?

◯ American Indian or Alaska Native ◯ Asian or Pacific Islander ◯ Black or African American
◯ Hispanic or Latino ◯ White or Caucasian

Select ALL that apply to you:

◯ I am a healthcare worker or work in a healthcare setting (paid or unpaid)

Facility type/Setting:

- ◯ Inpatient
- ◯ Outpatient
- ◯ Long term care facility
- ◯ Home health/hospice
- ◯ Laboratory
- ◯ Other

Primary activities:

- ◯ Direct patient care
- ◯ Indirect patient care
- ◯ Support

◯ I am an Emergency Medical Services (EMS) provider

◯ I am a Mortuary Services Provider

◯ I am a First Responder (non-EMS)

- ◯ Law Enforcement
- ◯ Fire Services
- ◯ Corrections Officer
- ◯ Other

◯ I live or work in a congregate or group setting (examples: Group home, Shelter, Correctional Facility)

◯ I have a condition that puts me at higher risk of severe illness or death from COVID-19*

◯ I work (paid or unpaid) in a K-12 school (include educators, administrators, bus drivers, support staff)

◯ I work in one of the following industries or settings: Food and Agriculture, Transportation and Logistics, Manufacturing, Public Safety, Food Service, Energy, Water and Wastewater, Legal, Media, Finance, Public Health

◯ None of the above apply to me

*Cancer, Chronic Kidney Disease, COPD, Heart conditions, Immunocompromised, Obesity, Severe Obesity, Pregnancy, Sickle Cell Disease, Smoking, Type 2 diabetes mellitus, Asthma, Cerebrovascular disease, Cystic

Provider: Family Medical Services, Inc.
(English Plaza Pharmacy, FMS Pharmacy, Montevallo Drug, Ross Bridge Pharmacy)

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