Harrison-Clarksburg Health Department

330 W. Main Street
Clarksburg, WV 26301
Phone:304-623-9308 Fax: 304-623-9364

Name: _____

Date of Birth: _____ Age: _____

Address: _____

_____

Phone #: _____

Race: Gender: M☐ F☐

Ethnicity: Hispanic ☐ Non-Hispanic ☐

Emergency _____

Contact Phone #: _____

Important Questions

		Yes	NO
1.	**Have You had a Vaccine in the last 14 days?**	☐	☐
2.	Are you sick today?	☐	☐
3.	Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐
4.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐
5.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐
6.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral	☐	☐
7.	Are you pregnant and or breast feeding?	☐	☐

Have you had any changes to the above questions since your first Covid-19 vaccine?

Yes ☐ **No** ☐

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

The HCHD Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice of Privacy Practices is subject to change. A copy of our Notice is available upon request. By signing this form, you acknowledge that the HCHD Notice of Privacy Practices was made available to you.

CONSENT

You must be at least 18 years of age to sign. If under the age of 18, a parent or guardian's signature is required. I authorize the HCHD healthcare providers to administer treatment as deemed necessary for care of the patient named above. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment. I have been given, read, or had explained to me the FAQ Sheet on COVID-19 Vaccination and VSAFE information. I have chosen to receive today and understand the risks and benefits.

Covid-19 Vaccine **Dose 1**

STOP! You MUST sign this form AT VACCINATION SITE

Signature: _____

Date: _____

FOR OFFICE USE ONLY

Date Vaccinated: _____

Manufacturer: _____

Lot #: _____

Site of Injection: **Rt.** **Lt.** Deltoid

Nurse Signature: _____

Covid-19 Vaccine **Dose 2**

STOP! You MUST sign this form AT VACCINATION SITE

Signature: _____

Date:

FOR OFFICE USE ONLY

Date Vaccinated: _____

Manufacturer: _____

Lot #: _____

Site of Injection: **R t.** **Lt.** Deltoid

Nurse Signature: _____

INSURANCE INFORMATION

INSURANCE: Primary _____

Policy # _____ Group: _____

Policy Holder Name: _____ DOB _____

Relationship to patient: _____

Secondary Insurance: _____

Policy # _____ Group: _____

Policy Holder Name: _____ DOB _____

Relationship to patient: _____

I Have No Insurance of any type ☐