SWEDISH | HEALTH FOR GOOD

COVID-19 Vaccine

Washington State Department of Health (DOH) Intake Form

The Washington State Department of Health requires we collect and report the following information to the Washington State Immunization Information System. We recognize that the options (i.e., Sex and Race) may not be representative of the community Swedish services and we ask you select the option that best aligns with your identities.

PLEASE PRINT LEGIBLY

TODAY'S DATE MM _____ DD _____ YYYY _____

NAME (Legal Last, Legal First) _____

DATE OF BIRTH MM _____ DD _____ YYYY _____ ◯ I am over the age of 18

SEX ◯Female ◯Male ◯Other ◯Unknown/Undifferentiated

ETHNICITY / RACE

◯American Indian or Alaska Native ◯White ◯Hispanic ◯Asian

◯Black or African American ◯Pacific Islander ◯Non-Hispanic ◯Other Race

EMAIL _____

PHONE _____

HOME ADDRESS _____

_____

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I understand that I am receiving a vaccine to prevent disease caused by COVID-19. This vaccine has been authorized by the US Food & Drug Administration (FDA) for use ages 16 and above, while ages 12 through 15 are under an Emergency Use Authorization (EUA). It is also approved under EUA for inidivduals 12 years of age and older who have been determined to have certain kinds of immunocompromise. There is no FDA approved vaccine to prevent COVID-19. I understand that I have the option to accept or refuse the vaccine and there are currently no FDA approved alternatives. I have had the opportunity to discuss the risk and benefits of this vaccine and any alternatives. I understand that there may be significant and potential risks and benefits of vaccination, and the extent to which they may occur, is not known at this time. Patient-facing caregivers and those at high risk of occupational exposure may get a booster shot of the Pfizer-BioNTech's Covid-19 vaccine at least 6 months after their Pfizer-BioNTech primary series. This is not for Moderna or Johnson & Johnson. The FDA approved or EUA status of available vaccines may have changes since the printing of this form. Please check the FDA.gov for current status.

Pregnant women and breastfeeding women have not been included in any COVID vaccine clinical trials to date, so there is currently no safety data specific for this population. I understand that if I am pregnant, plan to become pregnant, or are breastfeeding, it is strongly recommended speak to care provider before getting the vaccine.

By receiving this COVID-19 vaccine I am agreeing to the Swedish safety protocol, which requires those who receive the vaccine to remain in the vaccination area for at least 15 minutes following their vaccination. This additional time is for my safety and allows the vaccine team to monitor me in the event of a reaction.

I understand and agree that this consent form and records relating to my vaccination will be maintained in designated records, including, if applicable, my medical record and/or my occupational health record. I consent to the release of my information to state or federal health authorities (e.g. state immunization registries) for the purpose of tracking immunizations during the public health emergency. I was provided information on the CDC V-SAFE program. This program does health checks on the people who get the COVID-19 vaccine.

_____

PRINT NAME OF PATIENT

_____

PRINT NAME OF LEGAL REPRESENTATIVE (IF APPLICABLE)

_____

RELATION OF LEGAL REPRESENTATIVE (IF APPLICABLE)

_____

SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE

DATE MM _____ DD _____ YYYY _____ **TIME** _____ : _____ AM / PM

FOR OFFICIAL USE ONLY

◯ I have reviewed the screening and exclusion criteria with the patient. I have determined that the criteria for vaccination has been met and no contraindications exist. **OR**

◯ I have reviewed the screening and exclusion criteria with the patient. I have determined that they **DO NOT** meet the criteria for receiving the vaccine and/or the vaccine is contraindicated.

MANUFACTURER	_____
DOSE	_____
DATE	_____

PLACE LOT STICKER HERE

VACCINATOR NAME

_____

SERIES ◯ 1st Dose ◯ 2nd Dose ◯ 3rd Dose ◯ Booster

SITE ◯ Left Deltoid ◯ Right Deltoid ◯ _____

VACCINATION CLINIC LOCATION

_____