NORTON SOUND HEALTH CORPORATION

Providing quality health services and promoting wellness within our people and environment.

2020-2021 COVID-19 Vaccination Administration Form

Patient Name (Print): _____ Date of Birth: _____

Address: _____

Phone Number: _____

Vaccination Screening Questions

	YES	NO	Do not Know
Have you received the COVID-19 vaccine before?			
Have you had a vaccine in the past 14 days?			
Have you ever had shortness of breath, difficulty breathing, or any other severe allergic reaction to a vaccine or injectable medication?			
Will you be at your current location in 21 days (Pfizer) or 28 days (Moderna)?			

Required COVID-19 Vaccine Demographic Questions

Race:	Gender:	Occupation:

Do you have one of the health conditions from the list below?	YES	NO	Do not Know
Asthma, heart disease, liver disease, lung disease, kidney disease, diabetes, severe obesity, or are immunocompromised			

I have received, read, and understand the emergency use authorization fact sheet provided: *EUA Factsheet.* I understand the risks involved with receiving the vaccine. I have had the opportunity to ask any questions and have received answers to my satisfaction.

_____

Signature Date

Date Administered	Site Deltoid	Manufacturer	Lot #	Dose Number
/ /	R L	P M J		1 2
Signature of Administrator				