MYRTUE Medical Center

PATIENT STICKER

COVID-19 VACCINE (PLEASE CIRCLE & INITIAL WHICH PRODUCT YOU WANT TO RECEIVE):

PFIZER (AGES 12 & OLDER) _____ MODERNA (AGES 12 & OLDER) _____ JANSSEN (AGES 18 & OLDER) ____
PFIZER (AGES 5 TO 11 YEARS) _____ MODERNA (AGES 6 TO 11 YEARS) _____
PFIZER (AGES 6 MONTHS TO 4 YEARS) _____ MODERNA (AGES 6 MONTHS TO 5 YEARS) _____

The information you provide is intended to assure appropriate vaccine administration practices.
If a question is not clear, please ask a nurse to explain.

- Do you have symptoms of illness or a fever today?	☐ No	☐ Yes
- Have you recently tested positive for COVID-19?	☐ No	☐ Yes
- Do you have any allergies? If so, list:_____	☐ No	☐ Yes
- Have you ever had myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside of the heart)?	☐ No	☐ Yes
- Do you have a bleeding disorder or are on a blood thinner?	☐ No	☐ Yes
- Have you received hematopoietic cell transplant or CAR-T cell therapy since receiving your last COVID vaccine?	☐ No	☐ Yes
- Have you ever had a severe allergic reaction to any other vaccine or injection?	☐ No	☐ Yes
- Have you had a severe allergic reaction to any component of the vaccine that you have chosen to receive?	☐ No	☐ Yes
- Have you ever had an allergic reaction that caused hives, swelling or respiratory distress (including food, pets/animals, or medicines)? (must wait 30 minutes)	☐ No	☐ Yes
- Do you have a condition or are on a treatment that makes the immune system weak?	☐ No	☐ Yes
- Have you ever received another COVID-19 vaccine?	☐ No	☐ Yes
- Have you ever fainted in association with an injection?	☐ No	☐ Yes
- Have you ever had any dermal fillers?	☐ No	☐ Yes

I have read and have been given a copy of the Emergency Use Authorization (EUA) for this COVID-19 vaccine. Any questions that I had have been answered to my satisfaction. I believe that I understand the benefits and risks of COVID-19 vaccine. I ask to receive the vaccine today.

I AGREE TO WAIT 15-30 MINUTES FOR OBSERVATION AFTER RECEIVING THE VACCINE.

Signature: _____ **Date:** _____

Printed Name:_____

FOR CLINIC USE ONLY

Place sticker with COVID lot number

How long did the patient stay in the room after the vaccination?
Circle: 15 minutes or 30 minutes

Nurse's Signature: _____