DESERT OASIS HEALTHCARE
Your Health. Your Life. Our Passion.

Date: ______________________

Age:______

Pfizer Adult	1st Dose
Pfizer Peds	2nd Dose
Moderna	Additional Dose
J&J	Booster
Flu	

COVID-19 CONSENT/PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	**ADDRESS**		
CITY, STATE	**ZIP**	**HOME PHONE:**	**CELL PHONE:**
PATIENT DATE OF BIRTH	**SEX** ❑ **Male** ❑ **Female**	**MARITAL STATUS** ❑ **Single** ❑ **Married** ❑ **Other**______________	
RELATION TO PATIENT: ❑**spouse** ❑**parent** ❑**guardian**		**MOTHERS FIRST NAME**	
PARENT OR GUARDIAN NAME		**PARENT OR GUARDIAN ADDRESS (if different from patient)**	
PARENT OR GUARDIAN BIRTH DATE	**PARENT OR GUARDIAN CELL #**	**PARENT OR GUARDIAN HOME PHONE**	
Patient Race: ❑White ❑ Black or African American ❑American Indian or Alaska Native ❑ Asian ❑ Pacific Islander	**Patient Ethnicity** Hispanic or Latino ❑ Not Hispanic or Latino ❑	**PARENT OR GUARDIAN EMAIL**	

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	**ID NUMBER**	**PHONE**
PRIMARY DOCTOR/FAMILY DOCTOR	**NAME OF INSURED**	
IN CASE OF EMERGENCY CONTACT NAME	**RELATIONSHIP**	**PHONE NUMBER**

Please answer the following questions	
Are you feeling sick today?	**YES** ❑ **NO** ❑
Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 Infection?	**YES** ❑ **NO** ❑
Have you received passive antibody therapy (monoclonal antibodies or a convalescent serum) as treatment for COVID-19	**YES** ❑ **NO** ❑
Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of the COVID-19 vaccine, polysorbate, or any vaccine or injectable medication?	**YES** ❑ **NO** ❑
Do you have a weakened immune system caused by something such as HIV infection, cancer or do you take immunosuppressive drugs?	**YES** ❑ **NO** ❑
Do you have a bleeding disorder or are you taking a blood thinner?	**YES** ❑ **NO** ❑
Do you have a history of heparin-induced thrombocytopenia (HIT)?	**YES** ❑ **NO** ❑
Do you have a history of thrombosis with thromboytopenia following the Janssen COVID-19 vaccine or any other adenovirus-vectored COVID-19 vaccine?	**YES** ❑ **NO** ❑

Are you pregnant or breastfeeding	YES ❑ NO ❑
Do you receive dermal fillers?	YES ❑ NO ❑
Do you have a history of myocarditis or pericarditis?	YES ❑ NO ❑
Do you have a history of Guillian-Barre syndrome (GBS)?	YES ❑ NO ❑
Have you ever had an allergic reaction to (1) component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures, (2) Polysorbate, (3) a previous dose of COVID-19 vaccine (This would include a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	YES ❑ NO ❑
Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	YES ❑ NO ❑

PATIENT CONSENT

- I have read or had explained to me and understand the benefits, side effects and risks of receiving and risks of not receiving the COVID-19 vaccination.
- I have had the opportunity to ask questions and I have received satisfactory answers.
- I agree to stay at the DOHC vaccination site for at least 15 minutes after receiving the vaccine or as directed by DOHC staff.
- I authorize DOHC staff to notify my physician/practitioner and/or public health of the vaccine received, any adverse events experienced and/or to contact me with any follow-up if needed.

I consent to receive the COVID-19 Vaccine today	**I consent on behalf of the patient to receive the COVID-19 Vaccine today**
Print Name:	**Print Name:**
Date:	**Date:** **Relationship:**
Signature:	**Signature:**

4. VACCINE INFORMATION - DOHC STAFF USE ONLY:

Previous COVID-19 Vaccination? (Check COVID Card & appropriate box below)	
i. No previous COVID-19 Vaccination ☐	iv. 2nd dose Moderna ≥ 6 months ago? ☐
ii. 1st dose Moderna ≥ 28 days ago? ☐	v. 2nd dose Pfizer ≥ 6 months ago? ☐
iii. 1st dose Pfizer ≥ 21 days ago? ☐	vi. Janssen dose ≥ 2 months ago? ☐

Vaccine Date/Time	**COVID-19 Vaccine** **CHECK Vaccine CARD		**Site of Injection:**	**Administering Staff:**
Date: __________	Pfizer (12+ years) ☐	1st dose ☐	L arm / R arm	Staff Name: ________________
	Pfizer (5 - 11 years) ☐	2nd dose ☐		
	Moderna ☐	Additional dose ☐		
Time: __________	Janssen ☐	Booster dose ☐		Staff Signature: ________________
	Dose: __________ **mL**			
	Lot #: ______________	**Exp:**____________		