COVID-19 VACCINE ADMINISTRATION RECORD (VAR)
About the person getting injection (Please Print)

Patient Name: _____ Patient Age: _____

SCREENING QUESTIONS FOR PERSON RECEIVING INJECTION			
The questions below will help us decide if the vaccine may be given today. If you need help with these questions, please ask the clinic staff to help you.	Circle Your Answer		
1. Are you feeling sick today?	YES	NO	
2. Have you received a dose of COVID-19 vaccine?	YES	NO	
a. If yes, which product? Other:_____	PFIZER	MODERNA	J&J
3. Have you had a severe allergic reaction (e.g. anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?	YES	NO	
a. Was the severe allergic reaction after receiving a COVID-19 vaccine?	YES	NO	
b. Was the severe allergic reaction after receiving another vaccine or another injectable medication?	YES	NO	
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 in the last 90 days?	YES	NO	
5. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	YES	NO	

THIS SECTION FOR CLINIC USE ONLY						
Dose #	Brand	Lot #	Exp. Date	Manuf.	Dose (ML)	Site/Rte

Date:	Vaccine Administrator Full Name/Title:
Time:	Vaccine Administrator Signature:

Samaritan Health Services
PO Box 3000
Corvallis, OR 97330

Samaritan Health Services

Last Name: First Name: Middle Initial:

Date of Birth:_____/_____/_____ Age:_____ Sex : ☐ Male ☐ Female
M D Y

Mailing Address: City: Zip:

Phone number: (_____) _____-_____ Email: _____

☐ Minors 15 and older only: Check this box if you do not want your parent/guardian informed that you received a vaccine.

Insurance Provider:_____

ID #:_____ Person Code (Suffix):_____ Group #:_____

Subscriber Name_____ Relationship to Patient:_____

Subscriber DOB:_____

Hispanic Ethnicity? ☐ Yes ☐ No ☐ Unknown Primary Language:_____
Race: ☐ American Indian/ Alaska Native ☐ Hispanic/Latino ☐ Native Hawaiian/ Pacific Islander
☐ Black/ African American ☐ White ☐ Asian ☐ Other: _____

I have received, read & had questions answered about the Emergency Use Authorization (EUA) on the COVID-19 Vaccine to be given to me. I am aware that some people may experience physical responses to the injection, such as (but not limited to) injection site pain, light-headedness or fainting. I understand the benefits and risks and request that the vaccine be given to me or to the person named above for whim I am authorized to make this request.

I agree that I can review the Notice of Privacy Practices for Samaritan Health Services located at https://www.samhealth.org/patient-visitors/patient-privacy-rights.

Signature: _____ Date: _____