

COVID VACCINE ATTESTATION FORM



Patient's First Name

Patient's Last Name

MI

Date of Birth:

MM

DD

YYY

Patient Eligibility Group:

12 and older with No Qualifying Diseases

Have you ever received a dose of COVID-19 vaccine?

Yes No Don't Know Other

If you answered Yes to the question above, which vaccine product did you receive?

Pfizer Moderna Janssen/Johnson & Johnson Other

Have you had an allergic reaction to a component of the COVID-19 vaccine, including polyethylene (PEG), found in medications such as laxatives and preparations for colonoscopy procedures?

Yes No Don't Know

If you answered Yes to the question above, to which of these did you have a reaction?

Component of COVID-19 (PEG) Polysorbate
 Previous COVID-19 Dose

Have you ever had an allergic reaction to another vaccine or injectable medication?

Yes No Don't Know

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? This would include food, pet, environmental, or oral medication allergies.

Yes No Don't Know

Have you ever had COVID-19 and been told you have a diagnosis of MIS-C?

Yes No Don't Know

Have you received passive antibody therapy as a treatment for COVID-19?

Yes No Don't Know

Are you taking immunosuppressive drugs? If you answered Yes, at what time of day do you take immunosuppressive drugs? _____

Yes No Don't Know

Are you pregnant or breastfeeding?

Yes No Don't Know

Parent/Legal Guardian Acknowledgement:

Print First and Last Name (Parent/Legal Guardian):

Date:

Signature (Parent/Legal Guardian):