MOUNT NITTANY HEALTH

Adult COVID-19 Vaccination Agreement

Name: _____ Date of Birth: _____

Address: _____ Telephone #: _____

- **Are you** at least 18years of age? ☐ No ☐ Yes
- **Today**, do you have any of the following symptoms?
  - Fever (temperature greater than 100.4ºF) ☐ No ☐ Yes
  - Loss of taste and or smell ☐ No ☐ Yes
  - Cough and or shortness of breath ☐ No ☐ Yes
  - Nausea, vomiting, diarrhea ☐ No ☐ Yes
  - Fatigue, muscle or body aches ☐ No ☐ Yes
  - Any other cold or flu-like symptoms ☐ No ☐ Yes _____
- **Vaccination Status:**
  - Is this your first or second dose of the initial COVID-19 vaccine series? ☐ First ☐ Second ☐ No/NA
  - If this is a booster dose, which one? ☐ First ☐ Second ☐ Other _____
- **Have you** ever experienced any adverse symptoms or conditions from a previous COVID-19 vaccination? ☐ No ☐ Yes ☐ N/A

  If yes, please explain: _____
- **Have you** ever had a serious allergic reaction (i.e., anaphylaxis, swollen lips, tongue, throat, etc.) to any vaccination or medication in the past that required medical treatment or emergency evaluation? ☐ No ☐ Yes

  If yes, please explain: _____
- **Are you** moderately or severely immunocompromised per CDC criteria? ☐ No ☐ Yes
  If yes, has 28 days elapsed since completion of your initial vaccine series (or 2 months since completion of your initial monovalent booster dose)? ☐ No ☐ Yes
- **Have you** received a hematopoietic cell transplant (HCT) or CAR-T-cell therapy since receiving COVID-19 vaccine? ☐ No ☐ Yes

Attestation Acknowledgment and Signature:

- I acknowledge that I have received the Vaccine Information Sheet and, if applicable, COVID-19 Vaccine Emergency Use Authorization (EUA) Fact Sheet for the vaccine that I received.
- I understand that it is not possible to consider every possible side effect/complication to vaccination.
- I have had an opportunity to ask questions regarding the vaccination and my questions have been answered to my satisfaction.
- I understand the benefits and risks of the COVID-19 vaccine and request that the vaccine be given to me.
- I acknowledge that I have received the Notice of COVID-19 Immunization and Reporting Requirements and consent to informing the PA State Immunization Registry that I have received the COVID-19 vaccine.
- If I am an employee of Mount Nittany Health, I also consent to informing my employer, Mount Nittany Health, that I have received the COVID-19 vaccine.

Vaccine Recipient Signature: _____ Date: _____

Vaccinator Name (print): _____ Signature: _____ Date: _____