PassportHealth

# COVID-19 Worksheet

| Last Name | First Name | Middle Initial | Date of Birth | Age: | Gender: □ Female □ Male |
|---|---|---|---|---|---|
| | | | | | |

| Street Address | City | County | State | Zip Code |
|---|---|---|---|---|
| | | | | |

| Phone Number □ Cell □ Home ( ) | Social Security # | Ethnicity: Hispanic Origin ☐ Yes ☐ No | Race: □ American Indian/Alaskan Native □ Asian □ Black/African American □ White □ Native Hawaiian/Other Pacific Islander |
|---|---|---|---|
| | | | |

| Email Address: | If Under 18-Parent/Guardian Full Name & Phone |
|---|---|
| | |

## Medical Insurance Information

**Does patient have medical health insurance** ☐ Yes ☐ No If yes, please complete questions below

| | | | | |
|---|---|---|---|---|
| ☐ **Medicaid/Soonercare** | Medicaid Number: | First and Last name as it appears on card | Mothers Maiden Name: | |
| ☐ **Private Insurance** | Indicate Primary insurance: | Policy Holder: | Group No.: | Policy No.: |
| | Indicate Secondary insurance: | Policy Holder: | Group No.: | Policy No.: |
| ☐ **Medicare** | Do you have Medicare Part B: ☐ Yes ☐ No | Is Medicare Primary? ☐ Yes ☐ No | Medicare Number: | |

## Medical Screening

**1.** Do you have a fever (>100F), infection or current illness today? Yes No
**2.** Have you ever had a significant allergic reaction to a vaccine or other injection? Yes No
**3.** Are you pregnant, plan to be pregnant or currently breastfeeding? Yes No
**4.** Have you received passive antibody therapy as treatment for COVID-19? Yes No
**5.** Do you have a severely immunocompromising condition? Yes No
**6.** Do you have a bleeding disorder or are you taking a blood thinner? Yes No
**7.** Do you have an allergy to a component of the vaccine? Yes No
**8.** Have you received another vaccine in the last 14 days? Yes No

**Consent:** I, the undersigned, give my consent for the services that I am requesting from Passport Health and its entities/contractors. I acknowledge that I received the Vaccine Manufacturer COVID-19 Fact Sheet for Recipients and Caregivers prior to receiving the vaccine and have had the opportunity to ask questions.
I understand the benefits and risks of the vaccine and request it be administered to me or the person for whom I am authorized to make consent. I may request the Notice of Health Information Practices (HIPAA) and authorize my immunization record to be recorded with the OK State Health Department and released to employer, school, and/or physician if requested.

**Patient / Parent or Guardian Signature:**_____ **Relationship to Patient:**_____ **Date:**_____

***Office Use Only***

| Date & time | COVID Vaccine Vaccine | Moderna Manufacturer | Lot Number | Exp. Date | RA LA Deltoid Injection Site |
|---|---|---|---|---|---|
| | | | | | |

**Nurse/Vaccine Administrator:** _____

DATA ENTRY
OSIIS Complete?
□ Yes
□ No

Edmond: 14033 N. Eastern Ave. Edmond, OK 73013 (405)563-8961
Broken Arrow: 1615 Eucalyptus Ave. # 206 Broken Arrow, OK 74012 (918)770-4290