HARVARD
Family Physicians, P.C.
Family Medicine OB/GYN Pediatrics Pharmacy

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	Vaccine	Manufacturer	Lot Number	Exp. Date	Injection Site
	COVID VACCINE	Moderna			RA LA Deltoid

Nurse/Vaccine Administrator: _____

DATA ENTRY
OSIIS Complete?
□ Yes
□ No

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