CMC
CONWAY MEDICAL CENTER

FOR CMC PURPOSES ONLY	DO NOT WRITE IN THIS BOX
Vaccinator Reviewed Screening:	
Vaccination Anatomical Site:	
Vaccination Time:	
Vaccination Date:	

YOUR INFORMATION

Name:			
Date of birth:			
Address:			
Phone Number:		Email:	

Place "X" next to one choice in each column.

Gender:	Race:	Ethnicity:
Female	Black or African American	Hispanic or Latino
Male	White	Not Hispanic or Latino
Decline to Identify	American Indian or Alaskan Native	Unknown
Other	Asian	Decline to Identify
	Native Hawaiian or Other Pacific Islander	
	Unknown/Not Reported	

If FEMALE, please answer A & B.

A. I am currently pregnant. __ Yes __No
B. I am currently a nursing mother. __Yes __No

Are you currently sick? __Yes __No

Indicate any known allergies. (Place "X" next to any that apply)

Milk	Latex
Fish (bass, flounder, cod)	Gelatin/Egg protein
Eggs	Yeast
Crustacean shellfish (crab, lobster, shrimp)	Neomycin
Peanuts	Thimerosal
Tree nuts	Other
Wheat	
Soybeans	No existing or known allergies

Please answer all questions.

Have you ever had a serious reaction after receiving an immunization?

__Yes __No

Have you ever fainted or felt dizzy after receiving an immunization?

__Yes __No

Are you currently being treated for a long-term health problem such as heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, other blood disorder?

__Yes __No

Are you currently being treated for cancer, leukemia, AIDS, or any other immune system problem?

__Yes __No

Are you currently taking cortisone, prednisone, other steroids or anti-cancer drugs, or have you had X-ray treatments?

__Yes __No

Do you have a history of Guillain-Barre Syndrome?

__Yes __No

Have you had a seizure, brain, or nerve problem?

__Yes __No

During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?

__Yes __No

Are you pregnant or is there a chance you could become pregnant during the next month?

__Yes __No

List any vaccinations you may have received in the past 4 weeks.

VACCINATION ACKNOWLEDGMENT & CONSENT

I have read or had explained to me the 2020-2021 Vaccine Information Statement for the Covid-19 vaccine and understand the risks and benefits. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization. My medical record may be shared with my physician or other healthcare provider. I am requesting that the immunization be given to me. I hereby release the Conway Medical Center from any and all claims arising out of, in connection with or in any way related to my receipt of this immunization.

Please do not sign this until you are advised to at your vaccination appointment.

Signature:_____ Date:_____

Witness:_____ Date:_____