Vaccine Lot#:

First Name:	Last Name:	MI:
DOB:	Phone Number:	Email:
Address:		Apt/Room:
City:	State:	Zip:

Sex (Gender assigned at birth)
- ☐ Female
- ☐ Male
- ☐ Other: _____

Race
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other
- ☐ Pacific Islander
- ☐ White
- ☐ Other Asian
- ☐ Other Nonwhite
- ☐ Other Pacific Islander
- ☐ Unknown

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Identification Card # (Passport, ID, Driver's License): _____ **Patient SSN**: _____

Primary Insurance Carrier ID #: _____ **Grp #:** _____

Insurance Company: _____ Insurance Company Phone: _____

Insured's Name: _____ Relationship: _____ Insured's DOB: _____

Secondary Insurance Carrier ID #: _____ Insurance Company: _____

Insurance Company Phone #: _____ Insured's Name: _____ Relationship: _____

Is this the patient's First, Second or Booster of the COVID-19 vaccination? ☐ First Dose ☐ Second Dose ☐ Booster

Section 2: COVID-19 SCREENING QUESTIONS

Please check YES or NO for each Question. ****If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.**	**YES**	**NO**	**Don't know**
1. Are you feeling sick today?			
2. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine?			
3. Do you carry an Epi-pen for emergency treatment of anaphylaxis?			
4. For women, are you pregnant or is there a chance you could become pregnant?			
5. For women, are you currently breastfeeding?			
6. Have you had any other vaccinations in the past 14 days?			
If so, explain:_____			
7. In the past 14 days, have you tested positive for COVID-19?			
8. Have you had in the last 10 days: fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion, or runny nose, nausea, vomiting, or diarrhea?			

Section 3: CONSENT FOR SERVICES

This Agreement is between MD Toxicology Group, LLC and the undersigned individual in connection with administering the COVID-19 Vaccination.

With your consent MD Toxicology Group is administering the COVID-19 Vaccination to you.

Being of lawful age and in consideration of being permitted to receive the COVID-19 vaccination, you release and forever discharge MD Toxicology Group from all manner of actions, claims and demands for or by reason of any injury to you that may occur as a consequence of receiving the vaccination.

You understand you will be required to wait 15 minutes after receiving the vaccination to ensure there are no adverse reactions.

Signature: _____ Date: _____

Patient or Guardian (Circle One)