Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

ACCEPTANCE
COVID-19 VACCINE

PLEASE PRINT LEGIBLY

DOB (MM/DD/YY) ___/___/___

E or C #

LAST NAME

FIRST NAME

California Immunization Registry (CAIR) Required Information

Name of Health Plan Coverage (ie: Anthem Blue Cross, Kaiser, Cigna United Healthcare, None)

Mother's First Name

The vaccine is free, but DHS is allowed to bill the insurance company for an "administration fee". Thus, there is a question about insurance on the request form. DHS will not bill any workforce member for this fee in absence of insurance or failure of insurance to pay.

Insured Member ID Number

Group Number

ETHNICITY/RACE ☐American Indian/Alaskan ☐ Asian ☐ Black ☐ Filipino ☐Hawaiian/Pacific Islander ☐Hispanic ☐ Two or more Race ☐ White ☐ Other

IF YOU REQUEST THE COVID -19 VACCINE, PLEASE ANSWER QUESTIONS BELOW

YES	NO	CHECK THE APPROPRIATE BOX
☐	☐	Do you have any allergies? If Yes, to what: _____
☐	☐	Do you have a severe allergy (anaphylaxis) or hypersensitivity or other problems after getting a vaccine?
☐	☐	Do you carry an adrenaline autoinjector/EpiPen?
☐	☐	Do you have a fever or feel sick today?
☐	☐	Have you received an any other vaccinations in the past 14 days? If Yes, describe: _____
☐	☐	Are you immunocompromised or are on a medication that affects your immune system?
☐	☐	Have you received another COVID-19 vaccine? If Yes, type and date: _____
YES	**NO**	**FOR FEMALES ONLY**
☐	☐	Are you pregnant/breastfeeding or think you may be pregnant?

YOUR ACKNOWLEDGMENT AND SIGNATURE

- ✓ I have received and/or read the "Fact Sheet for Recipients and Caregivers" I have had an opportunity to ask questions which were answered to my satisfaction.
- ✓ I understand the benefits and risks of the COVID-19 vaccine.
- ✓ I understand that I will need the 2nd dose of the two dose series in 21 days.
- ✓ I consent to receive the COVID-19 vaccine. I authorize designated staff to administer the vaccine. I release DHS facility and its staff from any and all liability or for any injury, condition or damage incurred due to my receipt of the vaccine.

Signature _____ Date/Time _____

FOR CLINIC USE ONLY

Pfizer/BioNTech mRNA 30µg in 0.3ml IM

DATE GIVEN	Series Dose #	MANUFACTURER	LOT NO.	EXP. DATE	INJECTION SITE	ADMINISTERED BY (PRINT NAME)
___/___/___	☐ 1st ☐ 2nd	Pfizer			☐ Right Deltoid ☐ Left Deltoid	

COMMENTS:

REV 12/2020

☐ Entered into database, Initials_____