BYU
Student & MTC
Health Services

COVID Immunization Encounter Form

Patient Name: _____ **Birthdate:**____/____/____ **Age:** _____
Address: _____ **City:** _____ **State:** UT **Zip:** _____

Phone #: (_____) _____ **Email:** _____ **Birth Sex:** □ Male □ Female
Race: □ African American □ Alaska Native □ Asian/Pacific Islander □ Native American □ White Other;_____
Ethnicity: Hispanic □ Yes □ No BYU ID # _____

Insurance Policy Holder Name:_____**Birthdate:**____/____/____
Relation to patient:_____Phone #: (____) _____ **Address:** _____
Insurance Carrier:_____**Group #**_____**Policy ID#:**_____

Please answer these questions concerning the individual receiving immunizations today by checking the boxes	**Yes**	**No**
Are you moderately to severely sick and/or have you had a fever within the last 24 hours?	○	○
Do you have allergies to medications, food, latex, or any vaccine?	○	○
Have you had a serious allergic reaction in the past (anaphylaxis)?	○	○
Have you ever had an allergic reaction (of any severity) to mRNA COVID-19 vaccine or any of its components including polyethylene glycol (PEG) or polysorbate?	○	○
Do you carry an Epi-pen?	○	○
Have you been treated for COVID disease with Monoclonal antibodies/Convalescent plasma in the last 90 days?	○	○
Are you a child or adolescent taking aspirin therapy?	○	○
If you are female, are you pregnant or breastfeeding?	○	○
Have you been diagnosed with MIS-C or MIS-A in the last 90 days? (Multisystem Inflammatory Syndrome)?	○	○
HAVE YOU RECEIVED A PREVIOUS DOSE OF COVID-19 VACCINE? Manufacture and DATE:	○	○
Are you under the age of 18? If yes, what is your age?	○	○

I have been given a copy and have read or had explained to me, the information contained in the **Vaccine Information Statement(s)** about the disease(s) and vaccine(s). Any questions I had were answered to my satisfaction. I understand the benefits and risk of the vaccine(s) and request that the vaccine(s) indicated be given to me or the person for whom I am authorized to make this request. I certify that I have received a copy or been given the opportunity to read the **Notice of Privacy Practices**. I understand and agree that the BYU Student Health Center will share personal data related to my vaccination with the State of Utah as required by law and with other healthcare providers when medically necessary. I understand that I can give permission to the BYU Student Health Center to share personal data about this vaccination at my request, later. I hereby release the BYU Student Health Center and their employees from all claims arising from such immunizations.

JURISDICTION AND VENUE The terms and conditions contained within this agreement shall be governed by the laws of the State of Utah and shall be construed and interpreted in accordance with those laws. Any action or proceeding brought by either party which is based upon or derived from, or in any way related to this agreement shall be brought in a court of competent jurisdiction within the state of Utah. The parties hereto consent to their personal jurisdiction of said court.

I understand that my health insurance coverage could have certain restrictions and limitations. I agree to pay the full amount for any and all related charges, if they are not covered by my insurance for any reason. If I fail to pay for these services and charges within 90 days of receiving notice that the charges are not covered for any reason, my account may be turned over to a collection agency.

Due to the higher cost to provide insurance billing services, I understand that I will be charged the full cost of the vaccine services if my insurance company does not cover the costs for any reason. I hereby request and authorize the BYU Student Health Department to submit claims to my health coverage or insurance. I understand that if I have insurance that covers vaccine, I am not eligible for the Vaccine for Children program.

If patient is under age 18, parent or guardian must sign below. If you are age 18 or over, sign below for yourself:

Authorization Signature: _____ Date: _____

If Signature **IS NOT** Client's, Print Name _____ DOB: ___/___/_____ Relation _____

Date printed on Vaccine Fact Sheet: Pfizer and Moderna

*********BELOW FOR OFFICE USE ONLY *********

COVID-19	**Category**	**Site**	**Lot #**	**Dose**	Date of Service:____/____/_____
Moderna Dose #1	State			0.5	Notes:
Moderna Dose #2	State			0.5	
Pfizer Dose #1	State			0.3	
Pfizer Dose #2	State			0.3	
Booster dose: P M	State				
Pfizer Ped Dose 1	State			0.2	
Pfizer Ped Dose 2	State			0.2	
Nurse One ID#:		Nurse Two ID#:			□ Wait 15 minutes Time: