MOUNT NITTANY HEALTH

COVID-19 Vaccination Agreement

Name: _____ Date of Birth: _____

Address: _____ Telephone #: _____

Please answer the following questions:

Today, do you have any of the following symptoms?

- Fever (temperature greater than 100.4ºF) ☐ Yes ☐ No
- Loss of taste and or smell ☐ Yes ☐ No
- Cough and or shortness of breath ☐ Yes ☐ No
- Nausea, vomiting, diarrhea ☐ Yes ☐ No
- Any other flu like symptoms ☐ Yes ☐ No

In the past 90 days, have you tested positive for COVID-19 and recovered? ☐ Yes ☐ No

In the past 14 days, have you received another type of vaccination? ☐ Yes ☐ No

Have you ever had a serious reaction to a vaccination or medication in the past (anaphylaxis, swollen lips, tongue, throat, etc.) requiring medical treatment or emergency evaluation? ☐ Yes ☐ No

Attestation Acknowledgment and Signature:

- I attest and represent that I meet at least one of the currently applicable vaccination eligibility criteria as set forth by the PA Department of Health.
- I understand that it is not possible to consider every possible side effect/complication to vaccination.
- I have had an opportunity to ask questions regarding the vaccination and my questions have been answered to my satisfaction.
- I understand the benefits and risks of the COVID-19 vaccine and request that the vaccine be given to me.
- I acknowledge that I have received the Notice of COVID-19 Immunization and Reporting Requirements and consent to informing the PA State Immunization Registry that I have received the COVID-19 vaccine.
- If I am an employee of Mount Nittany Health, I also consent to informing my employer, Mount Nittany Health, that I have received the COVID-19 vaccine.

Vaccine Recipient Signature: _____ Date: _____

Vaccinator Name (print): _____ Signature: _____ Date: _____

(Rev: 3/31/21)