Wood County Health Department

COVID-19 Vaccine Administration Record and Screening

Information collected on this form will be used to document authorization for receipt of vaccines. The information will be shared through the Wisconsin Immunization Registry (WIR) and Registry for Effectively Communicating Immunization Needs (RECIN) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and confidential. **Please Print.**

Client Name: Last: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ First: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ MI: ☐

Previous last name(s):_____ **Mother's maiden name:**_____

Age: _____ **Date of Birth:** month:_____ day:_____ year:_____ **Gender:** ☐ Male ☐ Female ☐ Other

Address:_____ **City:**_____ **Zip:**_____ **Telephone:**_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Race:** ☐ Black/ African American ☐ American Indian ☐ Asian ☐ White ☐ Other Race

Questions for person receiving vaccine	**Yes**	**No**
1. Are you sick today? (fever, cough, shortness of breath, nausea/vomiting in the last 24 hours)	☐	☐
2. Have you received a previous dose of the COVID-19 vaccine? If so, which brand? _____ Date received: _____/_____/_____ Be prepared to show your card/documentation.	☐	☐
3. Have you ever had a **severe allergic reaction that required treatment with epinephrine/EpiPen or that caused you to go to the hospital, or that caused hives, swelling, wheezing, or respiratory distress to any of the following:** • A COVID-19 vaccine component (including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures)? • Polysorbate (which is found in some vaccines, film coated tablets, and IV steroids)? • A previous dose of COVID-19 vaccine, another vaccine, or injectable medication? List: _____ • Anything else (ex. other medication allergies, food, pets, venom, environmental allergies, etc.)? List: _____	☐	☐
4. Do you have a history of heparin-induced thrombocytopenia (HIT)? (*If within 90 days of diagnosis, mRNA vaccine [Moderna or Pfizer] is recommended. After 90 days, any COVID-19 vaccine may be offered.)*	☐	☐
5. Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection? (*consider delaying vaccination for 90 days after MIS; consult with health care provider*).	☐	☐
6. Have you received antibody therapy/convalescent plasma for COVID in the past 90 days? (*if so, defer vaccination until 90 days has passed since treatment*).	☐	☐
7. Are you currently in your isolation or quarantine period due to COVID-19?	☐	☐

I have answered the above questions to the best of my knowledge and request that I be immunized. I have been given a copy and have read, or have had explained to me, information about the diseases and the vaccine to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of receiving a vaccine approved under an Emergency Use Authorization from the FDA. I understand that if I have a dermal filler, I may experience temporary swelling at or near the site of the filler injection (usually face/lips) and will contact my health care provider if swelling develops. If I am a female between 18-49 years of age, I am aware of the rare but increased risk of thrombosis with thrombocytopenia syndrome after receipt of the Janssen vaccine and am aware of symptoms for which to watch, which are listed in the EUA Fact Sheet. I consent to receive the vaccine in a public location. I have been made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors. **I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me, or in the case that I am a guardian, my child.**

Consent obtained/Signature:_____ **Date:** _____

☐ **Written** ☐ **Verbal** (if verbal, vaccinator is to read full paragraph above to recipient) **Are you receiving** ☐ **Dose 1 or** ☐ **Dose 2?**

For Vaccinator/Office Use

Vaccine	Site	Trade name/Manufacturer Lot Number	Expiration Date
COVID-19	RD LD		

Signature and Title – Person Administering Vaccine:_____ Date:_____

Entered into WIR/RECIN by:_____Date:_____

Rev. 06/02/21