COVID-19 Vaccine Administration Record 2020-2021

Wright County Health Department
115 1st Street SE
Clarion, Iowa 50525

Section 1: Vaccine Recipient Information (Please Print)

Recipient Name: _____
Last First M.I.

Address: _____
Street City State Postal Code

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Phone Number _____ Primary Healthcare Provider: _____

Section 2: Screening for Vaccine Eligibility

Has the person listed above previously received COVID-19 vaccine? ☐ Yes ☒ No

If yes to above, indicate the COVID-19 vaccine previously received:

Vaccine Brand Administered Pfizer

Date first dose administered: Month _____ Day _____ Year _____

Date second does administered: Month _____ Day _____ Year _____

Section 3: Consent

I have read or have had explained to me the information provided in the Emergency Use Authorization (EUA) Factsheet or Vaccine Information Statement about COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be administered to me or to the person named above for whom I am authorized to make this request.

Signature: _____ Date: _____

Healthcare Provider Use Only

Date Vaccine Administered: _____ Injection Site (Deltoid): ☐ Left ☐ Right

Manufacturer: **Pfizer** Exp: _____ Lot Number _____

Signature: _____ Administered by: _____

☒ COVID-19 Vaccine EUA FACT SHEET for Recipients provided

Entered into Iris _____ Billed to Insurance NA Payment Received NA

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Name

Age

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **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 ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product			
• Did you bring your vaccination record card or other documentation? *(yes/no)*	☐	☐	
3. Have you ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following:			
o Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
o Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
4. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer)
- ☐ Take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of herparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers

Form reviewed by

Date

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists