# COVID-19 VACCINE ADMINISTRATION RECORD SHEET

LAST NAME FIRST MI BIRTHDATE AGE

MAILING ADDRESS CITY STATE ZIP CODE

PHONE RACE ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

**Please complete the Pre-vaccination Checklist on the back of this page.**

I have read or have had explained to me the information in the Emergency Use Authorization sheet (EUA) about the vaccine that will be administered. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine indicated above be given to me. I acknowledge and consent that my vaccination records are stored electronically in I-CARE. I agree to wait 15 minutes after vaccination to monitor for side effects.

X_____
Signature of person to receive vaccine

X_____
Date Signed & Emergency Use Authorization sheet provided

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**FOR OFFICE USE ONLY**

**P1 P2 P3 M1 M2 M3 J&J1 J&J2**

| Brand Name of Vaccine | Admin Date | EUA Date | Manufacturer | Lot # | Expiration Date | Site of Injection | Route |
|---|---|---|---|---|---|---|---|
| Moderna COVID-19 | | 10/20/21 | Moderna US Inc. | | | RD / LD | IM |
| Pfizer COVID-19 | | 10/29/21 | Pfizer-BioNTech | | | RD / LD | IM |
| Janssen COVID-19 | | 10/20/21 | Janssen Pharmaceutial | | | RD / LD | IM |

Form reviewed & vaccine administered by: _____ Date: _____

**Clinic/Office Address:** Pike County Health Department, 606 W. Adams, Pittsfield, IL 62363; (217) 285-4407, ext. 124

*Revised 11/2//21*

# Prevaccination Checklist for COVID-19 Vaccines

## For vaccine recipients:

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.

**Name** _____

**Age** _____

| | 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-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____ | | | |
| • Have you received a complete COVID-19 vaccine series *(i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna])*? | ☐ | ☐ | |
| • Did you bring your vaccination record card or other documentation? | ☐ | ☐ | |
| **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
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ 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 bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré Syndrome (GBS)

**Form reviewed by** _____ **Date** _____



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