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_____ X_____

Signature of person to receive vaccine Date: 50 Signed & Emergency Use Authorization sheet provided

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		01/07/22	Moderna US Inc.			RD / LD	IM
Pfizer COVID-19		01/03/22	Pfizer-BioNTech			RD / LD	IM
Janssen COVID-19		01/11/22	Janssen Pharmaceutical			RD / LD	IM

Form (Front & Back) reviewed & vaccine administered by: _____

Date: _____

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

Revised 01/12/2022

Name: _____ Age: _____

Prevaccination Checklist for COVID-19 Vaccination

	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(s) did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (J&J) ☐ Other Product: _____	☐	☐	☐
How many doses of COVID-19 vaccine have you received? _____			
Did you bring your vaccination record card or other documentation?	☐	☐	
3. Check all that apply: ☐ I live in a long-term care setting. ☐ I have been diagnosed with a medical condition(s). Please list: _____ ☐ I am a first responder. ☐ I work in a long-term care facility, correctional facility, hospital, restaurant, retail setting, school, or other setting with high exposure to the public.			
4. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)*	☐	☐	☐
5. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	☐	☐	☐
6. 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: a. Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
b. Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. 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.)*	☐	☐	☐
8. 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 ☐ Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19 ☐ 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 history of heparin-induced thrombocytopenia (HIT) ☐ Am currently pregnant or breastfeeding ☐ Have received dermal fillers ☐ Have a history of Guillain-Barré Syndrome (GBS)			

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists. CDC 11/23/21