

COVID-19 VACCINE ADMINISTRATION RECORD SHEET

LAST NAME	FIRST	MI	BIRTHDATE	AGE
MAILING ADDRESS		CITY	STATE	ZIP CODE
PHONE	RACE	ETHNICITY: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> 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 (Parent/Guardian if under 18)

X _____
Date: Signed & Emergency Use Authorization sheet provided

FOR OFFICE USE ONLY

Pfizer Primary:	Pfizer Booster:	Moderna Primary:	Moderna Booster:	J&J :
P1 P2 P3	PB1 PB2	M1 M2 M3	MB1 MB2	JJ1 JJ2

Brand Name of Vaccine	Admin Date	EUA Date	Manufacturer	Lot #	Expiration Date	Site of Injection	Route
Moderna COVID-19		06/22/22	Moderna US Inc.			RD / LD	IM
Pfizer COVID-19		05/17/22	Pfizer-BioNTech			RD / LD	IM
Janssen COVID-19		05/05/22	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

Name: _____

Age: _____

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 health care provider to explain it.

Prevaccination Checklist for COVID-19 Vaccination

	Yes	No	Don't Know
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever received a dose of COVID-19 vaccine? <ul style="list-style-type: none"> • If yes, which vaccine product(s) did you receive? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (J&J) <input type="checkbox"/> Other Product: _____ 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How many doses of COVID-19 vaccine have you received? _____			
Did you bring your vaccination record card or other documentation?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? <i>(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)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had an allergic reaction to: <i>(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.)</i> <ul style="list-style-type: none"> • A component of a COVID-19 vaccine, including either of the following: <ul style="list-style-type: none"> 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 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? <i>(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.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Check all that apply to you: <ul style="list-style-type: none"> <input type="checkbox"/> Am a female between ages 18 and 49 years old <input type="checkbox"/> Am a male between ages 12 and 29 years old <input type="checkbox"/> Have a history of myocarditis or pericarditis <input type="checkbox"/> Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19 <input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection <input type="checkbox"/> Have a bleeding disorder <input type="checkbox"/> Take a blood thinner <input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT) <input type="checkbox"/> Am currently pregnant or breastfeeding <input type="checkbox"/> Have received dermal fillers <input type="checkbox"/> Have a history of Guillain-Barré Syndrome (GBS) 			