Wood County Health Department

COVID-19 Vaccine Administration Record and Screening

For Ages 12+

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 with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is 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?	☐	☐
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. Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A)? (if yes, *defer vaccination and refer to person's health care provider for further discussion/evaluation*).	☐	☐
5. Do you have a history of myocarditis or pericarditis? (if yes, *defer vaccination and refer to person's health care provider for further discussion/evaluation*).	☐	☐
6. 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 of the COVID-19 Vaccine Information Fact Sheet and have read, or have had explained to me, information about the disease 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 receiving an "additional" dose, I attest that I am doing so due to having a weakened immune system. 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 COVID-19 vaccine be given to me, or in the case that I am a guardian, my child.**

☐ **Written** ☐ **Verbal** (if verbal, vaccinator is to read full paragraph above to recipient)

Consent obtained/Signature and relationship to child: _____ **Date:** _____

Are you receiving: ☐ **Dose 1** ☐ **Dose 2** ☐ **Additional Dose (immunocompromised)** ☐ **Booster Dose**

Type of vaccine receiving: ☐ **Moderna (0.5 ml)** ☐ **Pfizer 12+ (0.3 ml)**

For Vaccinator/Office Use (Rev. 09/08/22)

Vaccine	Site	Trade name/Manufacturer Lot Number	Expiration Date	Dose
COVID-19	RD LD			0.5 ml / 0.3 ml

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

Entered into WIR by:_____ Date:_____