# Pocahontas County Health Department
# COVID-19 Vaccine

**Section 1: Vaccine Recipient Information:**

Name: (Last) ______________________ (First) ______________________________(Middle)________________

Birthday: _____/______/_______ (age) _________ (Phone Number):_______________________________________

Address: ________________________________________________________________________________

City: _____________________________________ State: __________________________ Zip: _______________

Primary Care Physician: ___________________________________________________________________

**Section 2: COVID-19 Pre-Vaccination Assessment:** 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.

| | YES | NO | Don't know |
|---|---|---|---|
| 1. Are you feeling sick today? | | | |
| 2. Have you ever received a dose of COVID-19 vaccine?<br>• If YES, indicate the COVID-19 vaccine previously received:<br>Pfizer Moderna Janssen Other Date: | | | |
| 3. Have you ever had a severe allergic (e.g. anaphylaxis) to something?<br>For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?<br>• Was the severe allergic reaction after receiving a COVID-19 vaccine?<br>• Was the severe allergic reaction after receiving another vaccine or another injectable medication? | | | |
| 4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19? | | | |
| 5. Have you received another vaccine in the last 14 days? | | | |
| 6. Have you tested positive for COVID-19? If YES, what date: | | | |
| 7. Do you have a weakened immune system caused by something, such as HIV infection or cancer, or do you take immunosuppressive drugs or therapies? | | | |
| 8. Do you have a bleeding disorder or are you taking a blood thinner? | | | |
| 9. Are you pregnant or breastfeeding? | | | |
| 10. Will you follow the recommended post-vaccination observation time? (15 or 30 min) | | | |

**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 the person named above for whom I am authorized to make this request.

X______________________________________________________________ Date:__________________________

****************************************STAFF USE ONLY********************************************

**Staff Circle One: First Dose Second Dose Booster**

| Date Administered | Vaccine Manuf. | Vaccine Lot # | Exp. Date | VIS date | Dose | Site | Administered By: |
|---|---|---|---|---|---|---|---|
| | Moderna | | | | 0.25ml<br>0.5ml | **Right**<br>**Left**<br>Deltoid | |

IRIS Entered/Initial: _________ Date:_________ Time:_________