## Iowa County Health Department COVID-19 Vaccine Clinic

# Vaccine Administration Record and Screening

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) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and confidential.

**Client Name: Last:** | | | | | | | | | | | | | | | **First:** | | | | | | | | | | | | **MI:** |

**Age:** _____ **Date of Birth:** month:_____day:_____ year:_____ **Gender:** ☐ Male ☐ Female ☐ Other

**Address:**_____ **City:**_____ **Zip:**_____**Telephone:**_____

School District (if applicable) _____

**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. Are you currently in your isolation or quarantine period due to COVID-19? | ☐ | ☐ |
| 3. Have you ever had an observed severe allergic (anaphylactic) reaction to anything? If so, was it to a component of the COVID-19 vaccine including 1). Polyethylene glycol (PEG) found in laxatives and bowel preps and a component of the Moderna & Pfizer vaccine or 2). Polysorbate, a component of the Janssen vaccine, another vaccine, or an injectable (e.g. intramuscular, intravenous, or subcutaneous) therapy such as contrast dye. Please List: | ☐ | ☐ |
| 4. Have you received antibody therapy for COVID-19 for **post-exposure prophylaxis** in the past **30** days? | ☐ | ☐ |
| 5. Have you received antibody therapy or convalescent plasma for COVID-19 **treatment** in the past **90** days? | ☐ | ☐ |
| 6. Are you immunocompromised? Only including: Active treatment for solid tumor and hematologic malignancies, receipt of solid-organ transplant and taking immunosuppressive therapy, receipt of CAR-T-cell or hematopoietic stem cell transplant (within two years of transplantation or taking immunosuppression therapy), moderate or severe primary immunodeficiency (DiGeorge syndrome, Wiskott-Aldrich syndrome), advanced or untreated HIV infection, active treatment with high-dose corticosteroids (≥20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory | ☐ | ☐ |

***If you answered YES to any of these questions, you may not receive your vaccination today.**

I have been given a copy and have read, or have had explained to me, the COVID-19 Vaccine Fact Sheet for recipients and caregivers. 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 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 vaccine be given to me.**

**Signature**: _____ **Date:** _____

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**Minor (under age 18) receiving Pfizer vaccine: MUST be accompanied by an adult-age 18 years or older**

**Signature: (Parent or legal guardian)** _____ **Date:** _____

☐ **Written** ☐ **Verbal** **Are you receiving** ☐ **Dose 1** ☐ **Dose 2** ☐ **Dose 3** ☐ **Booster #1** ☐ **Booster #2**

| For Vaccinator | | | |
|---|---|---|---|
| Vaccine | Site | Trade name/Manufacturer Lot Number | Expiration Date |
| COVID-19 | RD<br>LD | _____ml (dose given) | |
| Signature and Title – Person Administering Vaccine:_____ Date:_____ | | | |