Immunization Information Form

COVID-19 Vaccine Administration

Recipient Information

Facility_____ **resident**_____**employee**_____ **patient**_____

First Name_____Middle Initial_____Last Name _____

DOB_____ Sex Male Female Unknown (circle one

Race (circle one)

White Black/African American Hispanic/ Latino Asian American Indian

Other Race _____ Unknown

Address

Street_____

City_____State_____Zip_____

Phone_____County_____D.L.#_____

Insurance Information

Medicare/ Medicaid #_____

Primary Ins holder_____ Insurer_____

ID number _____ Group number _____

SOC SEC#_____BIN#_____ PCN#_____

Primary Care Provider _____phone_____

I have read or had explained to me Emergency Use Authorization Fact Sheet or a Vaccine Information Statement for the COVID-19 vaccine and understand the risks and benefits. I give consent for this vaccine.

Patient/ authorized person Signature _____ Date _____

Form completed by_____Title_____Date_____

***** For Office Use ******

Vaccine Information

Dose Number	Date Administered	Administration Site	Manufacturer	Lot Number	Exp. Date	NDC

Vaccinator_____ Lic #_____

Signature_____ Date_____

Entered into Shot Records by_____ Date_____

Faxed to PCP _____ by_____ Date_____

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

The following questions will help us to 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, ask your healthcare provider to explain.

Patient Name :_____DOB _____Age_____

	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 did you receive? (circle one) Pfizer Moderna Janssen (J & J) Other			
3. Have you ever had an allergic reaction to: (This would also 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 occurred within 4 hours that caused hives, swelling or respiratory distress, including wheezing)			
* A component of a COVID-19 vaccine including either of the following: 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 intravenous steroids.			
* A previous dose of COVID-19 vaccine.			
* A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19) or an injectable medication? (This would also 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 occurred within 4 hours that caused hives, swelling or respiratory distress, including wheezing)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of the COVID-19 vaccine, or any other injectable medication? This would include food, pet, venom, environmental or oral medication allergies.			
6. Have you received any vaccines in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you have COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking blood thinners?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			