COVID-19 VACCINE ADMINISTRATION RECORD

I have been given a copy and read or have had explained to me the information in the Vaccine Information Statement(s) (VIS) or Emergency Use Authorization Use (EUA) of the COVID-19 Vaccine to prevent Coronavirus disease 2019. I agree that 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 request that the immunization be given to me or the person named below for whom I am authorized to make this request.

I agree to remain at the vaccination site for observation following the immunization. I understand and have been given information on local and systemic post-vaccination symptoms, treatment of post-vaccination local or systemic symptoms, if medically appropriate, and information on V-safe and VAERS vaccine adverse events.

I understand 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. **Please Print.**

Patient's Name (Last, First, Middle Initial):	Date of Birth:	Age:	☐ Male ☐ Female
Maiden Name:	Other last names you've had:		
Telephone Number:	County:		
Address:	City:	State:	Zip:
Ethnicity (check one): ☐ Hispanic ☐ Non-Hispanic	Race (check one): ☐ African American ☐ Asian ☐ Native American ☐ White ☐ Other		

Questions for person receiving vaccine:	**Yes**	**No**
1. Are you feeling sick today?		
2. Have you ever received a dose of COVID-19 vaccine? If Yes, when? _____ Which vaccine product? ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson		
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis)? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?		
a. Was the severe allergic reaction after receiving a COVID-19 vaccine?		
b. Was the severe allergic reaction from a component of a COVID-19 vaccine?		
c. Was the severe allergic reaction after receiving another vaccine or injectable medication?		
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? If yes, what date? ____ / ____ / ____		
5. Have you received any vaccine in the past 14 days? → If Yes, please list: _____		
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		
7. Do you have a weakened immune system caused by something such as HIV infection, 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? → If Yes, the Public Health Department cannot vaccinate you at this time.		
10. Are you breastfeeding? → If Yes, you must receive approval from your health care provider.		

By signing, I attest that the above individual is eligible to receive this vaccine. Signature consent of person to receive vaccine or authorized person. X_____	Date:

Official Use Only:

RHD 10.5.2021

Screening/Education Review: _____ Data Entry: _____