COVID-19 Coronavirus

Douglas County Health Department

******ARE YOU ALLERGIC TO LATEX? TELL NURSE IF YOU ARE! ******

PRINT name as shown EXACTLY on Medicare Card: (If applicable)

NAME: _____ ____ _____ **SEX:** M F
FIRST MI LAST

DATE OF BIRTH: ____/____/____ ____ **PRIMARY PHONE #:** ____-____-____
Month Day Year **Age**

_____ _____ _____ _____
STREET ADDRESS **CITY** **STATE** **ZIP CODE**

- I have read or have had explained to me the information in the Fact Sheet about the Emergency Use Authorization of the **Pfizer Covid-19 vaccine**. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the Covid-19 vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request.
- I, the undersigned, voluntarily agree to have the Covid-19 vaccine given to me (or the person named above). I have completed the pre-vaccination form. The person receiving this vaccine is in good health at this time and is not allergic to latex I understand that a physician consult is necessary prior to taking the vaccine for persons who have a history of bleeding disorder or on a blood thinner or have ever had a serious allergic reaction or other problems after getting any vaccination.
- I consent to allow information on this form, as well as the patient registration form, to be entered as necessary in the Illinois Immunization Registry (ICARE) and LCHD's electronic billing system.
- I have been provided information on V-Safe, a safety monitoring smartphone-based tool managed by CDC, and VaxText Messaging service for second-dose reminders.
- I will not hold the Douglas County Health Dept. or the nurse giving the vaccine responsible for any adverse reaction that may result from this vaccination.
- I authorize the release of any information necessary to process a Medicare, Medicaid or health insurance claim if applicable. I request payment of benefits to Douglas County Health Dept.
- I have been provided with Notice of Privacy Practices.

SIGNATURE:_____ **DATE:**_____

FOR NURSE USE ONLY: Fact Sheet Provided: ___ **Yes** ___ **No**

Vaccine Information: 2nd Dose Required: ___ **Yes** ___**No**

Manufacturer: Pfizer **Lot #:**
Dosage: 0.3ml **Expiration:**

Site: **Left Deltoid** **Right Deltoid**

Nurse Signature: _____ **Date/Time Administered:** _____

For DCHD Use Only:
Name Printed Clearly by Employee/Volunteer: _____

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name _____

Age _____

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 it.

	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? ☐ Pfizer ☐ Moderna ☐ Another product _____			
3. Have you ever had an allergic reaction to: (This would 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 the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
• Polysorbate			
• A previous dose of COVID-19 vaccine			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would 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 COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.			
6. Have you received any vaccine 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 had 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 a blood thinner?			
11. Are you pregnant or breastfeeding?			

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists