

Norman-Mahnomen Public Health COVID-19 Vaccine Screening and Agreement

Information collected on this form will be used to document that you have received the vaccine(s). Immunization information may be shared through the Minnesota Immunization Information Connection (MIIC) with other health care providers, schools, health departments, and others authorized under law to receive it. If you have any questions, please ask your health care provider. If you have questions about MIIC, refer to [MIIC and the Public](http://www.health.state.mn.us/people/immunize/miic/public.html) www.health.state.mn.us/people/immunize/miic/public.html or call 1-800-657-3970.

Contact Information – person being vaccinated

NAME (Last)		(First)	(M.I.)
DATE OF BIRTH Month _____ Day _____ Year _____		AGE	MOTHERS MAIDEN NAME (Last)
ADDRESS			
CITY	STATE	ZIP	DAYTIME PHONE NUMBER

Insurance Information

Private Insurance
 Medical Assistance
 Uninsured

Health History

Talk to your health care provider prior to vaccination if you answer yes to any of the following:

Yes	No	Unknown	Question
Yes	No	Unknown	Severe allergic reaction (e.g., anaphylaxis) to a previous dose of COVID-19 vaccine? If yes, please specify:
Yes	No	Unknown	History of severe allergic reaction (e.g., anaphylaxis) to a component of the COVID-19 vaccine?
Yes	No	Unknown	History of severe allergic reaction (e.g., anaphylaxis) to any other vaccine or injectable therapy (e.g., intramuscular (in the muscle), intravenous (in the vein), or subcutaneous (under the skin))?
Yes	No	Unknown	Have you received any vaccination in the last 14 days?
Yes	No	Unknown	Are you breastfeeding, pregnant, or planning to become pregnant?
Yes	No	Unknown	Are you feeling sick today?
Yes	No	Unknown	Received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days?
Yes	No	Unknown	Exposed to another person with known COVID-19 disease?
Yes	No	Unknown	Have you ever received a dose of COVID-19 vaccine? If yes, list vaccine product: _____ Date of dose: _____

Agreement

I acknowledge that I have read or had explained to me the Emergency Use Authorization Fact Sheet for the following COVID-19 vaccine: Pfizer. I have also had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described. I request that the COVID-19 vaccine be given to me or to the person named above for whom I am authorized to make this request.

Signature of patient or parent/guardian: _____ Date: _____

COVID-19 Vaccine Presentation ¹	EUA Fact Sheet Date	Route ²	Manufacturer ³	Lot Number	Admin Site ¹
COVID-19 (Pfizer)	04/06/2021	IM	Pfizer-BioNTech		

1. **Site Vaccine Given:** LD = Left Deltoid, RD = Right Deltoid, LT = Left Thigh, RT = Right Thigh

Signature and title of person administering vaccine: _____

Date administered: _____

ENTERED INTO MIIC
 FIRST DOSE
 SECOND DOSE