Health Department

COVID-19 VACCINE ADMINISTRATION RECORD

SECTION 1 CLIENT INFORMATION *(Please PRINT clearly)*

Today's Date: _____

Legal Name: _____
Last Name *First Name* *Middle Name*

Date of Birth: _____ **Other Names Used Since Birth:** _____
MM/DD/YYYY *(Maiden Name, etc.):*

Gender: ☐ Male ☐ Female

Address: _____
Street Address

_____
City *State* *Zip Code*

Phone Number: _____
(Area Code) Phone Number

Race:
☐ White
☐ Black/African American
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ Native Alaskan/American Indian
☐ Multi-Racial (Select all that apply)

Ethnicity:
☐ Non-Hispanic/Latino
☐ Hispanic/Latino

SECTION 2 MEDICAL SCREENING QUESTIONNAIRE

1. Are you currently ill or running a fever?	☐ Yes	☐ No
2. Have you received any vaccine within the past 14 days?	☐ Yes	☐ No
3. Have you ever had a severe allergic reaction to any of the following items? ▪ A previous dose of COVID-19 vaccine or any other vaccine ▪ Medication or therapy, polyethylene glycol (PEG) or polysorbate ▪ Food item, pet, insect, latex, environmental substance or any other substance	☐ Yes	☐ No
4. Do you have a low platelet count or a bleeding disorder?	☐ Yes	☐ No
5. Are you currently pregnant or breastfeeding?	☐ Yes	☐ No
6. Have you previously been treated for COVID-19 with monoclonal antibodies or convalescent plasma?	☐ Yes	☐ No

SECTION 3 CONSENT

CONSENT FOR SERVICES: I have read or have had explained to me, the information contained in the Emergency Use Authorization Fact Sheet regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s). I ask that the vaccine(s) be given to me, or to the person for whom I am authorized to make this request. I also authorize the Macomb County Health Department to release my immunization record information, or the immunization record information of the person for whom I am authorized to make this request to other health care provider(s) as needed and to other public health authorities (e.g. for entry into an immunization registry for Covid-19 Vaccine reporting requirements).

NOTICE OF PRIVACY PRACTICES: I have received notification of the Macomb County Health Department's Notice of Health Information Practices. I understand that my acknowledgement of the Notice is evidenced by my signature on this document. The Department is required to abide by the terms of this privacy notice. The Department may change the terms of its notice at any time. The new notice will be effective for all protected health information that it maintains at that time. Upon my request, the Department will provide me with the revised notice of privacy practices.

By signing below, I hereby acknowledge that I have read and fully understand the applicable statements on this form.

SIGNATURE of Client/Legal Guardian _____ Date _____

PRINT NAME of Client/Legal Guardian _____

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Office Use Only

SECTION 4	Vaccination Phase				
☐ **Phase 1A** *Priority One*	☐ **Phase 1A** *Priority Two*	☐ **Phase 1A** *Priority Three*	☐ **Phase 1B**	☐ **Phase 1C**	☐ **Phase 2**

SECTION 5	Registration Information			
Service Location	☐ 91 – MC Outreach ☐ 92 – SW Outreach ☐ 93 – SE Outreach	☐ Mount Clemens (01) ☐ Southwest (02) ☐ Southeast (03)	**Entered in MCIR by**	
			Date Entered in MCIR	

SECTION 6	Vaccine Documentation
Dose Number	☐ Covid-19 Vaccine Dose #1 ☐ Covid-19 Vaccine Dose #2
Vaccination Checklist	☐ Birthdate Confirmed ☐ Screening Questions Reviewed ☐ EUA Fact Sheet Given ☐ Provided COVID-19 Vaccination Record
Staff Administering Vaccine	
Date	

Vaccine	MFR	Lot #	Dose/Vol	Site		Route
Covid-19 mRNA	☐ Pfizer		☐ 30 mcg/ 0.3 mL dose	☐ Right Arm (Deltoid) ☐ Left Arm (Deltoid)	☐ Right Thigh ☐ Left Thigh	IM
Covid-19 mRNA	☐ Moderna		☐ 100 mcg/ 0.5 mL dose	☐ Right Arm (Deltoid) ☐ Left Arm (Deltoid)	☐ Right Thigh ☐ Left Thigh	IM
Covid-19 vector-nr	☐ Janssen		☐ 0.5 mL dose	☐ Right Arm (Deltoid) ☐ Left Arm (Deltoid)	☐ Right Thigh ☐ Left Thigh	IM

PROGRESS NOTES