Livingston County Department of Health COVID-19 Vaccination Clinic (Moderna 18+)

FIRST NAME											
STREET ADDRESS ZIP CODE TOWN COUNTY PHONE NUMBER EMAIL ADDRESS DATE OF BIRTH GENDER IDENTITY (CIRCLE) MALE FEMALE OTHER/NONBINARY **Optional** RACE (CIRCLE) Native American/Alaskan Native Multiracial HISPANIC Previous Vaccines: HISPANIC											
ZIP CODE TOWN					COUNTY						
PHONE NUMBER		EMAIL ADDRESS									
DATE OF BIRTH GENDER IDENTITY (CIRCLE)											
				OTHER/NONBIN	NARY						
Optional RACE (CIRCLE) **Optional** ETHNICITY (CIRCLE)					Previous Vaccines:						
Native American/Alaskan Native		Multiracial HISPANIC				1 1					
Asian/Pacific Islander White		NON	NON-HISPANIC		Date of 1 st //						
Black		Other				Date of 2 nd	/_				
Questions for the person receiving Countermeasure (circle appropriate answer)								No	Unk		
1. Will you be under the age of 18 on the day of your appointment?							Υ	N	U		
2. Are you feeling sick today?							Υ	N	U		
3. In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a healthcare provider or health department to isolate or quarantine at home due to Covid-19 infection or exposure?								N	U		
4. Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)?								N	U		
5. Have you ever had an immediate allergic reaction (e.g. hives, facial swelling, or difficulty breathing or anaphylaxis), to any vaccine, injection, shot, or to any component of the COVID-19 vaccine, or a severe allergic								N	U		
6. Are you pregnant or considering becoming pregnant?								N	U		
7. Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?								N	U		
8. Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?								U			
9. Do you have a bleeding disorder, a history of blood clots or are you currently taking a blood thinner? Y N U									U		
10. Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?									U		
11. Have you received 2 doses of the Pfizer vaccine, the second dose being at least 6 months ago?							Υ	N	U		
12. Have you received 2 doses of the Moderna vaccine, the second dose being at least 6 months ago?								N	U		
13. Have you received a previous dose of the Janssen COVID-19 vaccine?								N	U		
14. Have you ever received a previous dose of a COVID-19 vaccine recognized by the WHO but NOT by the FDA (AstraZeneca / VAXZEVRIA, Sinovax / CORONAVAC, Serum Institute of India / COVISHIELD, Sinopharm / BIBP)?								N	U		
15. NYS COVID Vaccine Certification Eligibility. I certify that I have read the Certification of Eligibility for Vaccination above. I certify under penalty of law that I am eligible for the COVID-19 Vaccination. I further agree that by clicking and selecting "Yes" and submitting this form, I am placing the legal equivalent of my handwritten signature on such certification								N	U		
	PHONE NUMBER DATE OF BIRTH **Optional** RACE (CIRC Native American/Alaskan Asian/Pacific Islander Black tions for the person red you feeling sick today? the last 10 days, have yo s or been told by a health ion or exposure? we you been treated with as)? we you ever had an immental and the person red you pregnant or consider you pregnant or consider you have cancer, leuker you take any medication ancer drugs, or have you you have a bleeding dise you have a history of maround the heart)? ave you received 2 dose ave you received 2 dose ave you received a previous and a pre	TOWN PHONE NUMBER TOWN PHONE NUMBER **Optional** RACE (CIRCLE) Native American/Alaskan Native Asian/Pacific Islander Black tions for the person receiving C Ill you be under the age of 18 on the you feeling sick today? the last 10 days, have you had a C on or exposure? In you been treated with antibody in so or been told by a healthcare proviou or exposure? In you ever had an immediate alled in you have cancer, leukemia, HIV/A you take any medications that affect ancer drugs, or have you had any received any on the you have a history of myocardities around the heart)? The you received 2 doses of the Pare you received 2 doses of the Pare you received a previous dose are you ever received a previous dose are gree that by clicking and selections.	TOWN PHONE NUMBER DATE OF BIRTH **Optional** RACE (CIRCLE) Native American/Alaskan Native Asian/Pacific Islander Black Other tions for the person receiving Countermeas: Ill you be under the age of 18 on the day of your expoure expoure expoure exposure? We you feeling sick today? The last 10 days, have you had a COVID-19 test is or been told by a healthcare provider or health ion or exposure? We you been treated with antibody therapy or cons)? We you ever had an immediate allergic reaction nylaxis), to any vaccine, injection, shot, or to any on (anaphylaxis) to anything? Expouregnant or considering becoming pregnally you have cancer, leukemia, HIV/AIDS or any or you take any medications that affect your immunancer drugs, or have you had any radiation treat you have a bleeding disorder, a history of blood or you have a history of myocarditis (inflammatic around the heart)? ave you received 2 doses of the Pfizer vaccine, ave you received 2 doses of the Moderna vaccine ave you received a previous dose of the Jansse ave you received	TOWN PHONE NUMBER DATE OF BIRTH	TOWN PHONE NUMBER EMAIL ADDRESS EMAIL ADDRESS DATE OF BIRTH GENDER IDENTITY (CIRCLE) MALE **Optional** RACE (CIRCLE) Native American/Alaskan Native Multiracial Asian/Pacific Islander White Black Other White NON-HISPANIC NON-HISPANIC NON-HISPANIC NON-HISPANIC NON-HISPANIC NON-HISPANIC Town and any appointment? Town and a COVID-19 test because you had symptoms and so or been told by a healthcare provider or health department to isolate or quarant ion or exposure? Town you be used an immediate allergic reaction (e.g. hives, facial swelling, or diffinglaxis), to any vaccine, injection, shot, or to any component of the COVID-19 vacon (anaphylaxis) to anything? Toyu pregnant or considering becoming pregnant? You have cancer, leukemia, HIV/AIDS or any other condition that weakens the iny you take any medications that affect your immune system, such as cortisone, precer drugs, or have you had any radiation treatments? You have a bleeding disorder, a history of blood clots or are you currently taking to you have a history of myocarditis (inflammation of the heart muscle) or pericard around the heart)? Toyu have a closes of the Pfizer vaccine, the second dose being at least of ave you received 2 doses of the Moderna vaccine, the second dose being at least of ave you received 2 doses of the Moderna vaccine, the second dose being at least of ave you received a previous dose of the Janssen COVID-19 vaccine? Toyu have cancer, leukemia, HIV/AIDS or any the second dose being at least of ave you received 2 doses of the Moderna vaccine, the second dose being at least of ave you received 2 doses of the Moderna vaccine, the second dose being at least of the preceived in the previous dose of the Janssen COVID-19 vaccine? Toyun the learty? Toyun the learty? Toyun the learty of the certific that I have read the Certification altion above. I certify under penalty of law that I am eligible for the COVID-19 vier agree that by clicking and selecting "Yes" and submitting this form, I am placiting agree that	TOWN COUNT	TOWN COUNTY	STREET ADDRESS TOWN	INITIAL		

FOR PROVIDER USE ONLY

PLACE COUNTERMEASURE LABEL HERE:											
Administratio	on site:										
Left Arm	Right Arm	Left Thigh	Right Thigh	Left Buttock	Right Buttock Other						
Provider Administering Countermeasure: Please Print & Sign											
Comments:											