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

RECIPIENT INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST 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
Asian/Pacific Islander
Black
Multiracial
White
Other

****Optional** ETHNICITY (CIRCLE)**

HISPANIC
NON-HISPANIC

Previous Vaccines:

Date of 1st __ __/__ __/__ __

Date of 2nd __ __/__ __/__ __

Questions for the person receiving Countermeasure (circle appropriate answer)	Yes	No	Unk
1. Will you be under the age of 18 on the day of your appointment?	Y	N	U
2. Are you feeling sick today?	Y	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?	Y	N	U
4. Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)?	Y	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 reaction (anaphylaxis) to anything?	Y	N	U
6. Are you pregnant or considering becoming pregnant?	Y	N	U
7. Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?	Y	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?	Y	N	U
9. Do you have a bleeding disorder, a history of blood clots or are you currently taking a blood thinner?	Y	N	U
10. Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	Y	N	U
11. Have you received 2 doses of the Pfizer vaccine, the second dose being at least 6 months ago?	Y	N	U
12. Have you received 2 doses of the Moderna vaccine, the second dose being at least 6 months ago?	Y	N	U
13. Have you received a previous dose of the Janssen COVID-19 vaccine?	Y	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)?	Y	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	Y	N	U

FOR PROVIDER USE ONLY

PLACE COUNTERMEASURE LABEL HERE:

Administration site:

Left Arm Right Arm Left Thigh Right Thigh Left Buttock Right Buttock Other

Provider Administering Countermeasure: **Please Print & Sign**

Comments: