Riley County Health Department

COVID-19, SARS-CoV-2, VACCINE ADMINISTRATION FORM

PATIENT INFORMATION (YOU WILL NEED TO SHOW YOUR ID TO THE SCREENERS)

Patient's First Name | Middle Name | Last Name

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name(s))	Birth Date / /	Age	Sex ❑ M ❑ F

Race: ❑ Asian/Pacific Islander/Other ❑ Black or African American ❑ Caucasian or White ❑ Native American/Alaska Native ❑ Hawaiian ❑ Unknown or Other

Ethnicity: Hispanic/Latino?: ❑ Yes ❑ No

Current Address	City	State	ZIP Code

Cell Phone No. ( )	Home Phone No. ( )	Email Address

IMMUNIZATION SCREENING, QUESTIONNAIRE, & ACKNOWLEDGMENT - FOR VACCINE RECIPIENT

1.	Are you feeling sick or experiencing a high fever today? If yes, please explain:	☐ Yes ☐ No
2.	Have you ever received a dose of COVID-19 vaccine? • If yes, which vaccine product? ☐ Moderna ☐ Pfizer ☐ Janssen (J&J) ☐ Other: _____ When (date): _____	☐ Yes ☐ No

3.	Have you ever had an allergic reaction to:
	• A component of a COVID-19 vaccine, including either of the following:
	  • Polyethylene glycol (PEG); found in some medications, such as laxatives and preparations for colonoscopy procedures
	  • Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids
	• A previous dose of COVID-19 vaccine
		
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

4.	Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? If yes, please list:	☐ Yes ☐ No
5.	Are you a female between ages 18 and 49 years old and will be receiving the Janssen COVID-19 vaccine today? ____ (initial) If yes, I have been informed of the rare but increased risk of thrombosis with thrombocytopenia syndrome (TTS) after receipt of the Janssen COVID-19 Vaccine.	☐ Yes ☐ No
6.	Are you a male between ages 12 and 29 years old and will be receiving an mRNA (Moderna or Pfizer) COVID vaccine today? ____ (initial) If yes, I have been informed of the risk of developing myocarditis (an inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart) after receipt of an mRNA vaccine. Low Risk.	☐ Yes ☐ No
7.	Do you have a history of myocarditis or pericarditis? (RCHD needs a prescription from your doctor's office to vaccinate)	☐ Yes ☐ No
8.	Have you had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental, or oral medication allergies? (wait 30 minutes)	☐ Yes ☐ No
9.	Have you had COVID-19 and were treated with monoclonal antibodies or convalescent serum? (defer vaccine for 90 days)	☐ Yes ☐ No
10.	Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection? (defer vaccine for 90 days after the date of diagnosis)	☐ Yes ☐ No
11.	Do you have a bleeding disorder and/or take a blood thinner? (hold firm pressure to the injection site for at least 2 minutes)	☐ Yes ☐ No
12.	Do you have a history of herparin-induced thrombocytopenia (HIT)? (mRNA vaccine encouraged over others if it has been 90 days or less since the illness has resolved. After 90 days, any FDA-authorized COVID-19 vaccine.)	☐ Yes ☐ No
13.	Do you have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies? (Discuss an additional dose of an mRNA COVID-19 vaccine after an initial 2-dose primary mRNA series – need to complete "Additional mRNA COVID Vaccine Dose Attestation" form. Minimum of 28 days after completion of the initial 2-dose series.)	☐ Yes ☐ No
14.	Have you received dermal fillers? (Infrequently, these people might experience temporary swelling at or near the site of filler injection, usually the face or lips, following a COVID-19 vaccine. Contact your healthcare provider if swelling occurs.)	☐ Yes ☐ No
15.	Do you have a history of Guillain-Barre Syndrome (GBS)? (mRNA vaccine encouraged over Janssen due to possible association between the Janssen COVID-19 Vaccine and an increased risk of GBS)	☐ Yes ☐ No

VACCINE CONSENT

I have been offered a copy of the Vaccine Information Statement(s) (VIS) and/or Emergency Use Authorization (EUA) Fact Sheet for the vaccine checked below. I have read, had explained to me, and understand the information. I understand and am aware I am advised to wait for 15 to 30 minutes post vaccination for monitoring. I ask that the vaccine checked below be given to me or to the person named above for whom I am authorized to make this request. ☐ Moderna, mRNA-1273 ☐ Pfizer & BioNTech, BNT 162b2 ☐ Johnson & Johnson, Janssen

Signature of Patient or Legal Parent/Guardian: Date:

FOR OFFICE USE ONLY

Nursing Documentation

Manufacturer:		**Injection Site:**	Left	Deltoid
Lot # / Exp.	*(place syringe sticker here)*		Right	

Vaccine Administrator: **Date:**

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www.rileycountyks.gov/health

IN CASE OF EMERGENCY

Name of Emergency Contact	Relationship to Patient	Phone No.
		( )

UNIVERAL CONSENT FORM – COVID-19 VACCINE ONLY

PRIVACY PRACTICES (HIPAA)

All records of services rendered are considered confidential. I acknowledge that I have been offered a copy of the Riley County Health Department's Notice of Privacy Practices with the effective date of April 2019.

ELECTRONIC COMMUNICATION OPT-IN

By signing below I agree to and opt-in to receiving notifications through any notification systems currently used by Riley County via text and/or email.

SIGNATURE **DATE** .