Clinic:____ **TEMPLATE** Today's Date: ____________________

COVID-19 Vaccination Form

Please complete each field below with the information that applies to the client receiving services today.

CLIENT INFORMATION

Name (Last, First, MI)	**Suffix (eg., Jr, III)**	**Date of Birth**	**Age†**

Street Address	**City**	**State**	**Zip**	**County**

Phone Number ( ) ☐ Cell ☐ Home	**Sex** ☐ Female ☐ Male ☐ Other ☐ Unknown	**Race** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other	**Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

If the client is under 18 years of age, please complete guardian information.
Guardian relationship to client: ☐ Father ☐ Mother ☐ Legal Guardian ☐ Other **Guardian Name (Last, First)** ____

CONSENT FOR SERVICE

I, the undersigned, give my consent for the services that I am requesting from (*Provider Name)*____________________and its entities/contractors. I understand that:

-- the risks and benefits for these services will be explained to me and that I will have the opportunity to ask questions.

-- the information regarding myself and the services I receive will be entered into state Immunization Information System.

-- I may refuse service at any time.

I acknowledge that I have received a copy of (*Provider Name*)__________________________________Privacy Statement as required by the Health Information Portability and Accountability Act (HIPAA). I can also find a copy on the agency website. I also acknowledge that I received (*Vaccine Name)*______________________________ COVID-19 Fact Sheet for Recipients and Caregivers prior to receiving the vaccine.

Client/Guardian Signature: ____ Date: ___________________________

SCREENING FOR VACCINE COMPLICATIONS

For adult patients and parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child the COVID-19 vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
Does the person to be vaccinated have a fever today (>100° F orally)?	☐	☐	☐
Does the person to be vaccinated have severe allergies?	☐	☐	☐
Does the person to be vaccinated have an allergy to a component of the vaccine or have had an allergic reaction to a previous dose of the vaccine?	☐†	☐	☐
Is the person to be vaccinated on a blood thinner or have a bleeding disorder?	☐	☐	☐
Is the person to be vaccinated immune compromised or on a medicine that affects the immune system?	☐	☐	☐
Is the person to be vaccinated pregnant, planning to become pregnant, or currently breastfeeding?	☐	☐	☐

†Client must be aged 16 years or older and have no allergies to the COVID-19 vaccine or component of the vaccine to receive the vaccine.

Client Name (Last, First, MI) ____ Client DOB (MM/DD/YYYY)______________________________

<table>
<tr><td colspan="4">OFFICE USE ONLY – DO NOT WRITE BELOW</td></tr>
<tr><td>Vaccine Manufacturer:
Lot #:
Exp. Date:</td><td>Site:
☐ LT DELTOID IM
☐ RT DELTOID IM
☐ LT VAST LAT IM
☐ RT VAST LAT IM</td><td>EUA*/VIS given? ☐ Y ☐ N
Reaction? ☐ Y ☐ N</td><td>Dose Number:
☐ 1st ☐ 2nd</td></tr>
<tr><td colspan="4">Vaccination Complete? ☐Complete ☐Refused ☐Not administered ☐Partially administered ☐No recorded completion status</td></tr>
<tr><td colspan="4">Provider Signature:</td></tr>
</table>

*EAU = Emergency Use Agreement

Progress Note:____

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