COVID-19 Vaccine Administration Record and Screening

Information collected on this form will be used to document authorization for receipt of vaccines. The information will be shared through the Wisconsin Immunization Registry (WIR) and Registry for Effectively Communicating Immunization Needs (RECIN) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and confidential. **Please Print.**

Client Name: Last: | | | | | | | | | | | | | | | First: | | | | | | | | | | | | MI: |

Previous last name(s):_____ **Mother's maiden name:**_____

Age: _____ **Date of Birth:** month:_____ day:_____ year:_____ **Gender:** ☐ Male ☐ Female ☐ Other

Address:_____ **City:**_____ **Zip:**_____ **Telephone:**_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Race:** ☐ Black/ African American ☐ American Indian ☐ Asian ☐ White ☐ Other Race

Questions for person receiving vaccine	**Yes**	**No**
1. Are you sick today? (fever, cough, shortness of breath, nausea/vomiting in the last 24 hours)	☐	☐
2. Have you received a previous dose of the COVID-19 vaccine? If so, which brand? _____ Date received: ___/___/_____ Be prepared to show your card/documentation.	☐	☐
3. Have you ever had an allergic reaction to: • A COVID-19 vaccine component (including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures)? • Polysorbate? • A previous dose of COVID-19 vaccine, another vaccine, or injectable medication?	☐	☐
4. Have you ever had a **severe immediate allergic reaction (anaphylaxis requiring treatment with epinephrine)** to something other than items listed in #3. This would include food, environmental, venom, pets, and oral medications. If so, please list: _____	☐	☐
5. Have you received antibody therapy or convalescent plasma for COVID in the past 90 days?	☐	☐
6. Have you received another vaccine in the past 14 days?	☐	☐
7. Are you currently in your isolation or quarantine period due to COVID-19?	☐	☐

I have answered the above questions to the best of my knowledge and request that I be immunized. I have been given a copy and have read, or have had explained to me, information about the diseases and the vaccine to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of receiving a vaccine approved under an Emergency Use Authorization from the FDA. I consent to receive the vaccine in a public location. I have been made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors. **I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me, or in the case that I am a guardian, my child.**

Consent obtained/Signature:_____ **Date:** _____

☐ **Written** ☐ **Verbal** **Are you receiving** ☐ **Dose 1 or** ☐ **Dose 2?**

For Vaccinator/Office Use			
Vaccine	Site	Trade name/Manufacturer Lot Number	Expiration Date
COVID-19	RD LD		

Signature and Title – Person Administering Vaccine:_____ Date:_____

Entered into WIR/RECIN by:_____Date:_____

Rev. 01/20/21