**COVID-19 Vaccination Screening, Consent, and Administration Record**

**If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated.**

Information collected on this form will be shared with other vaccine providers through the Wisconsin Immunization Registry (WIR) to help assure accurate completion of the COVID-19 vaccine series. **PLEASE PRINT**

**Name -** Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_

**Age**: \_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_ **Assigned sex at birth**: 🗖M 🗖F 🗖Intersex

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip**: \_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity**:

🗖 African American/Black

🗖 American Indian or Alaska Native

🗖 Asian

🗖 Caucasian/White

🗖 Hispanic or Latino

🗖 Native Hawaiian or Pacific Islander

🗖 Other race, ethnicity, or origin

|  |  |  |
| --- | --- | --- |
| **Questions for the person receiving vaccine:** | **Yes** | **No** |
| 1. Are you feeling sick today? | 🗖 | 🗖 |
| 1. Have you ever had a positive test for COVID-19 or has a medical provider ever told you that you had COVID-19? **If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 🗖 | 🗖 |
| 1. Have you ever received a dose of COVID-19 vaccine?   **If yes, which vaccine product did you receive?**  🗖 Moderna 🗖 Pfizer 🗖 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 🗖 | 🗖 |
| 1. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum/plasma) as treatment for COVID-19 in the past 90 days? **If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 🗖 | 🗖 |
| 1. Have you ever had an allergic reaction to: 2. A component of the COVID-19 vaccine, including Polyethylene Glycol (PEG), which is found in some medications, such as laxatives? 3. Polysorbate? 4. A previous dose of COVID-19 vaccine? | 🗖  🗖  🗖 | 🗖  🗖  🗖 |
| 1. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? | 🗖 | 🗖 |
| 1. Have you ever had a **severe allergic or anaphylactic reaction** to something for which you had to go to the hospital, be treated with Epinephrine (an EpiPen), or that caused you to develop hives, swelling, or breathing problems (including wheezing) within 4 hours?   *This includes severe allergic or anaphylactic reactions to foods, pets, environmental, and oral medications.* | 🗖 | 🗖 |
| 1. Have you received any vaccine in the last 14 days? | 🗖 | 🗖 |
| 1. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? | 🗖 | 🗖 |
| 1. Do you have a bleeding disorder or are you taking a blood thinner? | 🗖 | 🗖 |
| 1. Are you pregnant or breastfeeding? | 🗖 | 🗖 |

* I have been given a copy and have read, or have had explained to me, information about COVID-19 vaccine.
* 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 agree to the required monitoring for post-vaccination reactions based on my risk factors.
* **I understand the benefits and risks of vaccine requested and ask that the vaccine be given to me (or to the person for whom I am a guardian).**

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ This consent is for: 🗖 Dose 1 🗖 Dose 2

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *For Vaccination Clinic Staff Use Only* | | | | |
| **Form reviewed by**: | | | | **Date**: |
| **Vaccine** | **IM Injection Site** | | **Trade Name/Manufacturer and Lot Number** | **Expiration Date** |
| COVID-19 | Right  Deltoid | Left  Deltoid |  |  |
| **Signature and Title of Vaccinator:** | | | | **Date:** |
| **Entered into WIR by:** | | | | **Date:** |