



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) 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:

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

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

Email Address: _____ Medicare/Medicaid Number: _____

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)	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you currently in your isolation for COVID-19 or have you been in close contact with someone who tested positive for COVID-19 in the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
3a. Have you ever had an anaphylactic reaction?	<input type="checkbox"/>	<input type="checkbox"/>
3b. Have you ever had an anaphylactic reaction to a component of the COVID-19 vaccine, another vaccine, or an injectable (e.g., intramuscular, intravenous, or subcutaneous) therapy? List:	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you moderately or severely immunocompromised?	<input type="checkbox"/>	<input type="checkbox"/>
5. I attest that I am at least 12 years of age and eligible receive the COVID-19 booster dose.	<input type="checkbox"/>	<input type="checkbox"/>

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 by the FDA or 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 Signature: _____ Date: _____

Are you receiving Dose 1 Dose 2 Dose 3 Booster

For Vaccinator				
Vaccine	Dosage	Site	Trade name/Manufacturer Lot Number	Expiration Date
COVID-19	.5 .3	RD		
	.25 .2	LD		
Signature and Title – Person Administering Vaccine: _____				Date: _____