Green County Public Health COVID Vaccine Clinic

Vaccine Administration Record and Screening

Green County Public Health
Prevent. Promote. Protect.

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)	☐	☐
2. Are you currently in isolation after testing positive for COVID-19, or have you been exposed to someone with COVID-19 in the past 10 days?	☐	☐
3a. Have you ever had an anaphylactic reaction? 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:	☐ ☐	☐ ☐
4. Have you received a COVID-19 vaccine in the past two months?	☐	☐

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 chil**d.

Consent Signature: _____ **Date:** _____

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For Vaccinator

Vaccine	Dosage	Site	Trade name/Manufacturer Lot Number	Expiration Date
COVID-19	.5 .25	RD LD		

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