Vaccine Administration Record
Consent for COVID-19 Vaccination

Please print legibly

First Name:________________________ **Middle Name:**________________ **Last Name:** _______________________ **Age:**________

Date of Birth:_________________**Address:**__________________________**City:**____________________**State:**_________**Zip:** _____________

Phone:_____________________________ **Mobile** **or** **Home**

Gender: (circle one) Female or Male

Ethnicity: (circle one) Non-Hispanic / Hispanic / Unknown

Race: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White

I certify that I am: (a) the patient and at least 18 years (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to Livingston County Health Department staff to administer the vaccine(s)) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the EUA Fact Sheet on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately **15 minutes** after administration. I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("I-CARE"). LCHD will enter your vaccination information in the State's ICARE information system for tracking and recording purposes. You will receive a vaccine card to be used to document each vaccination.

SCREENING QUESTIONS. The following questions will help us determine your eligibility to be vaccinated today. Circle yes, no, or don't know.

1. Are you feeling sick today? — Yes No Don't Know
2. Have you ever had an allergic reaction to a component of a Covid vaccine or a previous Covid vaccine or any other vaccine or injectable medication (this would include a severe allergic reaction that required treatment with epinephrine or an EpiPen that caused you to go to the hospital or caused hives, swelling, or respiratory distress, including wheezing?) — Yes No Don't Know
3. Do you have a health condition that makes you moderately or severely immunocompromised? (ex: treatment for cancer, HIV, organ transplant,) — Yes No Don't Know
4. Have you received COVID-19 vaccine before or during hematopoietic cell transplant or CAR-T-cell therapies? — Yes No Don't Know
5. Have you ever received a dose of COVID-19 vaccine? If yes which product? And how many doses? — Yes No Don't Know

   Pfizer __________

   Moderna __________

   J&J __________
6. Check all that apply to you:

   Have a history of myocarditis or pericarditis.

   Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A).

   History of an immune-medicated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)

   Have a history of thrombosis with thrombocytopenia syndrome (TTS).

   Have a history of Guillain-Barre Syndrome (GBS).

   Have history of COVID-19 disease within the past 3 months.

******TURN OVER FOR ACKNOWLEDGEMENT AND SIGNATURE******

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient or representative, and, based upon clinical observation, have sufficient knowledge of the patient's condition to answer the Screening Questions. I also acknowledge that I have read and agree to the terms and conditions as listed on the previous page and give my consent for the vaccine. I have also had a chance to ask questions and that such questions were answered to my satisfaction.

Patient/Authorized Person Signature:___________________________________ Date:_________________________

STOP

This portion to be filled out by LCHD staff

Complete AFTER vaccine administration

Dose 1		Dose 2		Dose 3	
Date of Vaccination & EUA Fact Sheet Given		Date of Vaccination & EUA Fact Sheet Given		Date of Vaccination & EUA Fact Sheet Given	
Site of Admin		Site of Admin		Site of Admin	
Vaccinator		Vaccinator		Vaccinator	
Date Entered into ICARE		Date Entered into ICARE		Date Entered into ICARE	
Vaccine	COVID-19	Vaccine	COVID-19	Vaccine	COVID-19
Manufacturer		Manufacturer		Manufacturer	
Vaccine Lot#		Vaccine Lot#		Vaccine Lot#	
Vaccine NDC#		Vaccine NDC#		Vaccine NDC#	
Vaccine Exp Date		Vaccine Exp Date		Vaccine Exp Date	
Vaccine Dosage		Vaccine Dosage		Vaccine Dosage	
EUA Fact Published Date		EUA Fact Published Date		EUA Fact Published Date	

BOOSTER	
Date of Vaccination & EUA Fact Sheet Given	
Site of Admin	
Vaccinator	
Date Entered into ICARE	
Vaccine	COVID-19
Manufacturer	
Vaccine Lot#	
Vaccine NDC#	
Vaccine Exp Date	
Vaccine Dosage	
EUA Fact Published Date	