Public Health
Prevent. Promote. Protect.
Clinton County Health District

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COVID- 19 VACCINE ADMINISTRATION RECORD

DATE OF SERVICE	FIRST NAME	MIDDLE INITIAL	LAST NAME

DATE OF BIRTH	AGE	PRIMARY INSURANCE & MEMBER ID NUMBER
		SECONDARY INSURANCE & MEMBER ID NUMBER
STREET ADDRESS		

RACE
- ☐ Alaskan Native (5)
- ☐ American Indian (5)
- ☐ Asian (4)
- ☐ Black (2)
- ☐ Native Hawaiian (7)
- ☐ Pacific Islander (7)
- ☐ White (1)
- ☐ Other (6)
- ☐ Unknown (9)

ETHNICITY
- ☐ Hispanic/Latino (1)
- ☐ Not Hispanic/Latino (2)
- ☐ Unknown (3)

SEX
- ☐ Female (F)
- ☐ Male (M)
- ☐ Other (O)
- ☐ Unknown (U)

CITY	STATE	ZIP	PHONE NUMBER

PATIENT QUESTIONS – ANSWER THE DAY OF VACCINATION

Have you ever had a severe allergic reaction to a vaccine or any injection in the past?	☐ No	☐ Yes
Have you ever tested positive for COVID-19 or had a doctor tell you that you had COVID-19?	☐ No	☐ Yes
Have you been identified as either a probable or confirmed case of COVID-19 in the last two weeks?	☐ No	☐ Yes
Have you received antibody therapy (monoclonal or convalescent plasma) for COVID-19 in the last 3 months?	☐ No	☐ Yes
Do you have any serious health conditions (often called co-morbidities)?	☐ No	☐ Yes
Do you have a weakened immune system (ie, from HIV or cancer) or are you on immunosuppressive drugs?	☐ No	☐ Yes
Do you have a bleeding disorder or are you taking a blood thinner?	☐ No	☐ Yes
Do you feel sick today?	☐ No	☐ Yes
Is this your first, second, or third dose?	☐ First dose	☐ Second dose ☐ Third dose

Are you in any group? (select only one)

- ☐ Individuals 65 and older
- ☐ Individuals aged 50 to 64 with certain underlying medical conditions
- ☐ Individuals ages 18-49 who are at high risk foe severe COVID -19 due to certain underlying medical conditions
- ☐ Individuals ages 18-64 who are at increased risk for COVID-19 exposure and transmission because of occupational or institutional setting
- ☐ Other

*Eligible booster recipients will be asked to attest they have one of the qualifying conditions, but specific proof will not be required.

Please visit the CDC website cdc.gov/coronavirus/2019-ncov/vaccines/index.html to learn about the benefits and risks (VIS) of the COVID-19 vaccine. By signing below, you agree that 1) you understand the benefits and risks of the vaccine and you are asking that the vaccine be given to you or the person named on this form for whom you are authorized to make this request, 3) you hereby consent that we can bill your insurance, if applicable, 4) you authorize the release of this vaccination record and all information on this form to your state's Immunization Program and the CDC, and 5) we can release this record to your doctor, school, or employer if requested. If the person who is being vaccinated is age 17 or under, by signing below you agree that you are authorized to consent to the vaccination of the patient and the patient on this form may receive vaccine with or without you, as the parent or guardian, present at the time of vaccination. After receiving your vaccine, we recommend you wait at least 15 minutes. If you leave the vaccination site before 15 minutes has passed after your vaccination you assume any risks associated with not waiting the recommended amount of time. Please be aware that staff may be taking pictures for social media and clinic improvement purposes. If you do not want your picture to be taken, please let us know at the clinic.

PATIENT CONSENT/SIGNATURE (or parent/guardian if patient is age 17 or under)	DATE OF CONSENT
X	/ /

OFFICE USE ONLY

VACCINE NAME	LOT NUMBER	EUA PROVIDED	V SAFE PROVIDED	MANUFACTURER & DOSAGE
COVID-19		☒ Yes	☒ Yes	☐ Moderna (MOD)- 0.5 mL ☐ Pfizer (PFR)- 0.3 cc ☐ Johnson & Johnson (JNJ)- 0.5mL
VACCINATOR INITIALS	**ROUTE OF ADMIN**	**SITE OF INJECTION**	**NOTES**	
	☒ IM ☐ TD ☐ IV ☐ NS ☐ SC ☐ ID ☐ O ☐ Other	☐ RD ☐ LD ☐ RT ☐ LT		