



## COVID-19 VACCINE ADMINISTRATION RECORD

### SECTION 1 CLIENT INFORMATION (Please PRINT clearly)

Today's Date: \_\_\_\_\_

Legal Name: \_\_\_\_\_

Last Name

First Name

Middle Name

Date of Birth: \_\_\_\_\_

MM/DD/YYYY

Other Names Used Since Birth: \_\_\_\_\_

(Maiden Name, etc.):

Gender:

☐ Male

☐ Female

Address: \_\_\_\_\_

Street Address

City

State

Zip Code

Phone Number: \_\_\_\_\_

(Area Code) Phone Number

Race:

☐ White

☐ Black/African American

☐ Asian

☐ Native Hawaiian/Pacific Islander

☐ Native Alaskan/American Indian

☐ Multi-Racial (Select all that apply)

Ethnicity:

☐ Non-Hispanic/Latino

☐ Hispanic/Latino

### SECTION 2 MEDICAL SCREENING QUESTIONNAIRE

1. Are you currently ill or running a fever? ☐ Yes ☐ No

2. Have you received any vaccine within the past 14 days? ☐ Yes ☐ No

3. Have you ever had a severe allergic reaction to any of the following items?

▪ A previous dose of COVID-19 vaccine or any other vaccine

▪ Medication or therapy, polyethylene glycol (PEG) or polysorbate

▪ Food item, pet, insect, latex, environmental substance or any other substance

☐ Yes ☐ No

4. Do you have a low platelet count or a bleeding disorder?

☐ Yes ☐ No

5. Are you currently pregnant or breastfeeding?

☐ Yes ☐ No

6. Have you previously been treated for COVID-19 with monoclonal antibodies or convalescent plasma?

☐ Yes ☐ No

### SECTION 3 CONSENT

**CONSENT FOR SERVICES:** I have read or have had explained to me, the information contained in the Emergency Use Authorization Fact Sheet regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s). I ask that the vaccine(s) be given to me, or to the person for whom I am authorized to make this request. I also authorize the Macomb County Health Department to release my immunization record information, or the immunization record information of the person for whom I am authorized to make this request to other health care provider(s) as needed and to other public health authorities (e.g. for entry into an immunization registry for Covid-19 Vaccine reporting requirements).

**NOTICE OF PRIVACY PRACTICES:** I have received notification of the Macomb County Health Department's Notice of Health Information Practices. I understand that my acknowledgement of the Notice is evidenced by my signature on this document. The Department is required to abide by the terms of this privacy notice. The Department may change the terms of its notice at any time. The new notice will be effective for all protected health information that it maintains at that time. Upon my request, the Department will provide me with the revised notice of privacy practices.

**By signing below, I hereby acknowledge that I have read and fully understand the applicable statements on this form.**

SIGNATURE of Client/Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_

PRINT NAME of Client/Legal Guardian \_\_\_\_\_

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## Office Use Only

SECTION 4 Vaccination Phase					
<input type="checkbox"/> <b>Phase 1A</b> <i>Priority One</i>	<input type="checkbox"/> <b>Phase 1A</b> <i>Priority Two</i>	<input type="checkbox"/> <b>Phase 1A</b> <i>Priority Three</i>	<input type="checkbox"/> <b>Phase 1B</b>	<input type="checkbox"/> <b>Phase 1C</b>	<input type="checkbox"/> <b>Phase 2</b>

SECTION 5 Registration Information				
<b>Service Location</b>	<input type="checkbox"/> 91 – MC Outreach <input type="checkbox"/> 92 – SW Outreach <input type="checkbox"/> 93 – SE Outreach	<input type="checkbox"/> Mount Clemens (01) <input type="checkbox"/> Southwest (02) <input type="checkbox"/> Southeast (03)	<b>Entered in MCIR by</b>	
			<b>Date Entered in MCIR</b>	

SECTION 6 Vaccine Documentation						
<b>Dose Number</b>	<input type="checkbox"/> Covid-19 Vaccine Dose #1 <input type="checkbox"/> Covid-19 Vaccine Dose #2					
<b>Vaccination Checklist</b>	<input type="checkbox"/> Birthdate Confirmed <input type="checkbox"/> Screening Questions Reviewed <input type="checkbox"/> EUA Fact Sheet Given <input type="checkbox"/> Provided COVID-19 Vaccination Record					
<b>Staff Administering Vaccine</b>						
<b>Date</b>						
Vaccine	MFR	Lot #	Dose/Vol	Site		Route
Covid-19 mRNA	<input type="checkbox"/> Pfizer		<input type="checkbox"/> 30 mcg/ 0.3 mL dose	<input type="checkbox"/> Right Arm (Deltoid) <input type="checkbox"/> Left Arm (Deltoid)	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh	IM
Covid-19 mRNA	<input type="checkbox"/> Moderna		<input type="checkbox"/> 100 mcg/ 0.5 mL dose	<input type="checkbox"/> Right Arm (Deltoid) <input type="checkbox"/> Left Arm (Deltoid)	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh	IM
Covid-19 vector-nr	<input type="checkbox"/> Janssen		<input type="checkbox"/> 0.5 mL dose	<input type="checkbox"/> Right Arm (Deltoid) <input type="checkbox"/> Left Arm (Deltoid)	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh	IM

PROGRESS NOTES	