Doniphan County Health Department/Home Health

COVID-19 VACCINE ADMINISTRATION RECORD

PATIENT INFORMATION

Name _____ **Age**_____ **DOB** _____ **Sex:** Male Female
(First) (Last) (MI) (Date of Birth)

Mailing Address _____ **City** _____ **State** ____ **Zip Code** _____

Phone Number _____ **Primary Care Physician:** _____

I have been given a copy and have read, or had explained to me, the information in the current federal COVID-19 Emergency Use Authorization Fact Sheet for Recipients and Caregivers and ask that the COVID-19 vaccine be given to me or to the person named for whom I am authorized to make this request. I acknowledge that I understand the Vaccine is not FDA approved, but is authorized for emergency use. I consent to the inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named above. I acknowledge that I understand that DPCOHD/HH is required to report to the Vaccine Adverse Event Reporting Systems (VAERS) any adverse events. I also acknowledge that I have received or been offered a copy of the Doniphan County Health Dept./Home Health Notice of Privacy Practices with the effective date of February 4, 2016.

Recipient/Parent/Guardian Signature _____ **Date**_____

HEALTH SCREENING QUESTIONNAIRE

1. Is the patient currently experiencing a high fever or other signs of illness?	Yes	No
2. Has the patient had a confirmed positive case of COVID-19 in the past 90 days? **If yes,** date of COVID-19 diagnosis: _____/_____/_____	Yes	No
3. Has the patient had a severe allergic reaction to vaccine or medication? (lightheadedness, recurrent emesis, requiring epinephrine or other emergency medical intervention)	Yes	No
• Was the severe allergic reaction after receiving a COVID-19 vaccine?	Yes	No
• Was the severe allergic reaction to ingredients of the COVID-19 vaccine?	Yes	No
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?	Yes	No
4. Is the patient immunocompromised or is the patient on a medicine that affects their immune system?	Yes	No
5. Has the patient received passive antibody therapy as a treatment for COVID-19 within the last 90 days?	Yes	No
6. Is the patient pregnant or planning to become pregnant?	Yes	No
7. Is the patient breastfeeding?	Yes	No
8. Has the patient received another COVID-19 vaccine? If yes, which vaccine product? ☐ Moderna ☐ Pfizer ☐ Other Product_____	Yes	No
9. Is the patient 16 years of age or older for Pfizer or 18 years of age or older for Moderna	Yes	No

INSURANCE INFORMATION

Name of Insured: _____

☐ Medicare: ID#_____

☐ Medicaid/Kancare: ID#_____ Aetna Sunflower United

☐ Private Insurance: ID# _____ Group# _____

Insurance Co. _____ Name of Policy Holder_____

Relationship to insured: Self Spouse Child Other

☐ No Health Insurance

PROVIDER INFORMATION					
Vaccine Provider: Doniphan Co. Health Dept./Home Health Agency			**Clinic Site:** DPCOHD		
Street Address:	**State**	**Zip Code**	**Street Address:**	**State**	**Zip Code**
201 S. Main St. PO Box 609, Troy	KS	66087	201 S. Main St. Troy	KS	66087

FOR CLINICAL USE ONLY

(Circle the appropriate vaccine, dose, extremity, site, route, and enter the manufacturer, lot #, and expiration date)

VACCINE	DOSE	EXT.	SITE	ROUTE	FACT SHEET DATE	MFR./LOT #	EXP. DATE
Pfizer-BioNTech COVID-19 Vaccine	**1 2**	**RT LT**	**Deltoid Vastus Lat.**	**IM 0.3 mL**	**12/2020**		
Moderna COVID-19 Vaccine	**1 2**	**RT LT**	**Deltoid Vastus Lat.**	**IM 0.5 mL**	**12/2020**		

NOTES:

Signature and Title of Vaccine Administrator **Date**