

**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? <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Janssen (J&J) <input type="checkbox"/> Other  Product _____	Yes	No
9. Is the patient <b>16 years</b> of age or older for Pfizer or <b>18 years</b> of age or older for Moderna & Janssen	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

<b>Vaccine Provider:</b> Doniphan Co. Health Dept./Home Health Agency			<b>Clinic Site:</b> DPCOHD		
<b>Street Address:</b> 201 S. Main St. PO Box 609, Troy	<b>State</b> KS	<b>Zip Code</b> 66087	<b>Street Address:</b> 201 S. Main St. Troy	<b>State</b> KS	<b>Zip Code</b> 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
<b>Pfizer-BioNTech COVID-19 Vaccine</b>	1   2	RT	Deltoid	IM 0.3 mL	12/2020		
		LT	Vastus Lat.				
<b>Moderna COVID- 19 Vaccine</b>	1   2	RT	Deltoid	IM 0.5 mL	12/2020		
		LT	Vastus Lat.				
<b>Janssen (J&amp;J) COVID-19 Vaccine</b>	1	RT	Deltoid	IM 0.5mL	02/2021		
		LT	Vastus Lat.				

**NOTES:**

\_\_\_\_\_  
Signature and Title of Vaccine Administrator

\_\_\_\_\_  
Date