Doniphan County Health Department/Home Health

COVID-19 VACCINE ADMINISTRATION RECORD

PEDIATRIC COVID VACCINE 6 mon-11yrs

Moderna(6 mon-4 yr) 1 2 **Pfizer**(6mon -4yrs) 1 2 3 **Pfizer**(5yrs-11yrs) 1 2 3

PATIENT INFORMATION

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

Mailing Address ______________________ **City** ______________ **State** ______ **Zip Code** ________

Phone Number ________________ **Primary Care Physician:** ____________________

Race: □ White □ African American □ Amer. Indian/Alaska Native □ Asian/Pacific Islander □ Other

Ethnicity: □ Non-Hispanic □ Hispanic □ Unknown

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.

Parent/Guardian Signature ______________________ **Date**____________

HEALTH SCREENING QUESTIONNAIRE	
1. Are you currently experiencing a high fever or other signs of illness?	Yes No
2. In the last 2 weeks have you tested positive for COVID-19 or are you currently being monitored for COVID-19?	Yes No
3. In the last 2 weeks, have you had contact with anyone who tested positive for COVID-19?	Yes No
4. Have you received passive antibody therapy as a treatment for COVID-19 within the last 90 days?	Yes No
5. Have you ever had a severe allergic reaction to vaccine or medication? (Lightheadedness, recurrent emesis, requiring epinephrine or other emergency medical intervention)	Yes No
6. Are you immunocompromised or is the patient on a medicine that affects their immune system?	Yes No
7. In the past 4 weeks, have you received a TB Skin Test?	Yes No
8. Do you have any allergies to any medications, food, vaccine, or latex?	Yes No N/A

INSURANCE INFORMATION

- ☐ No Health Insurance
- ☐ Medicaid/KanCare: ID# ____________________ Aetna Sunflower United
- ☐ Private Insurance: ID# ____________________ Group# ____________________

Insurance Co. ____________________ Name of Policy Holder ____________________

Relationship to insured: Child Other Social Security # of Policy holder ________

PROVIDER INFORMATION

Vaccine Provider:			Clinic Site:		
Doniphan Co. Health Dept./Home Health Agency			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	EUA DATE	MFR./LOT #	EXP. DATE
Pfizer-BioNTech COVID-19 Vaccine 6 mon-4yrs (maroon) 5-11 (orange) can boost	1 2 3 4	RT LT	Deltoid Vastus Lat.	IM 0.2 cc	06/17/22		
Pfizer-BioNTech COVID-19 Vaccine 5-11 (orange) can boost	1 2 3 4	RT LT	Deltoid Vastus Lat.	IM 0.2cc All Doses	06/17/22		
Moderna COVID-19 Vaccine 6 mon – 5 yrs (drk blue)	1 2	RT LT	Deltoid Vastus Lat.	0.25cc All doses	06/17/22		
Moderna COVID-19 Vaccine 6-11 yrs (drk blue)	1 2 3	RT LT	Deltoid Vastus Lat	0.5cc All Doses	6/17/22		

NOTES:

Signature and Title of Vaccine Administrator

Date