Doniphan County Health Department/Home Health

COVID-19 VACCINE ADMINISTRATION (12 yrs and older)

Moderna (18 years and older) 1 2 3 **Primary** **Pfizer** (12yrs and older) 1 2 3 **Primary**

Moderna Bivalent Booster 1 **Pfizer Bivalent Booster** 1

PATIENT INFORMATION

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

Mailing Address ____________________________________ **City** ___________________ **State** _______ **Zip Code** __________

Phone Number __________________________ **Ethnicity**: ☐ Non-Hispanic ☐ Hispanic ☐ Unknown

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

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 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

Question		
1. Are you 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. Have you received passive antibody therapy as a treatment for COVID-19 within the last 90 days?	Yes	No
4. Have you ever had a severe allergic reaction to vaccine or medication? (Light headedness, 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
5. Are you immunocompromised or is the patient on a medicine that affects their immune system?	Yes	No
6. Have you received another COVID-19 vaccine? If yes, which vaccine product? ☐ Moderna ☐ Pfizer ☐ Janssen	Yes	No
7. Has it been 2 months since your last Covid Vaccine (primary series or booster)?	Yes	No
8. .Are you **12 years** of age or older for Pfizer **or** **18 years** of age or older for Moderna?	Yes	No

INSURANCE INFORMATION

☐ Medicare: ID#_____________________________ ☐ No Health Insurance

☐ Medicaid/KanCare: ID#________________________________ Aetna Sunflower United

☐ Private Insurance: Insurance Co. ____________________ Name of Policy Holder_____________________________________

ID# ___________________________ Group# ________________

Social Sec # of Policy Holder __________________________ **Relationship to insured: Self Spouse Child Other**

Updated 09/12/2022

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	FACT SHEET DATE	MFR./LOT #	
Pfizer-BioNTech COVID-19 Vaccine	**1 2 3**	**RT LT**	**Deltoid Vastus Lat.**	**IM 0.3 mL**	**08/31/22**		
Pfizer-BioNTech COVID-19 Vaccine Bivalent Booster	**1**	**RT LT**	**Deltoid Vastus Lat.**	**IM 0.3 mL**	**08/31/22**		
Moderna COVID-19 Vaccine	**1 2 3**	**RT LT**	**Deltoid Vastus Lat.**	**IM 0.50 mL**	**08/31/22**		
Moderna COVID-19 Vaccine Bivalent Booster	**1**	**RT LT**	**Deltoid Vastus Lat.**	**IM 0.5 mL**	**08/31/22**		

NOTES:

Signature and Title of Vaccine Administrator

Date

Updated 09/12/2022