COVID-19 CLINIC Vaccine Administration Record and Screening

Information collected on this form will be used to document authorization for receipt of vaccines. The information will be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and confidential. **Please Print.**

Client Name: Last: | | | | | | | | | | | | | | | **First:** | | | | | | | | | | | | **MI:** |

Age: _____ **Date of Birth:** month:_____day:_____ year:_____ **Gender:** ☐ Male ☐ Female ☐ Other

Address:_____ **City:**_____ **Zip:**_____**Telephone:**_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Race:** ☐ Black/ African American ☐ American Indian ☐ Asian ☐ White ☐ Other Race

Please indicate which dose your child will be receiving :

1st/Starting the series: ◯ 2nd/Completing the series: ◯
Booster (> 5 months from original series): ◯

Questions for person receiving vaccine	**Yes**	**No**
1. Are you sick today? (fever, cough, shortness of breath, nausea/vomiting in the last 24 hours)	☐	☐
2. Are you currently in your isolation or quarantine period due to COVID-19?	☐	☐
3. Have you ever had an observed anaphylactic reaction to any substance either medication or environmental (insect stings, food allergies, other vaccinations, etc.)?	☐	☐
4. Have you received antibody therapy or convalescent plasma for COVID treatment in the past 90 days?	☐	☐
5. Have you received another vaccine in the past 14 days?	☐	☐

I have been given a copy and have read, or have had explained to me, information about the diseases and the vaccine to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of receiving a vaccine approved by the FDA ages 16 and up, approved under an Emergency Use Authorization from the FDA ages 5-15. I consent to receive the vaccine in a public location. I have been made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors. **I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me, or in the case that I am a guardian, my child.**

Parent/Guardian Signature:_____ **Date:** _____

For Vaccinator					
Dose 1 Name/Manufacturer Lot Number	Site	Dose 1 Administered by	Dose 2 Name/Manufacturer Lot Number	Site	Dose 2 Administered by
	RD LD	Signature:_____ Date:_____		RD LD	Signature:_____ Date:_____