



Douglas County Health Department

***ARE YOU ALLERGIC TO LATEX? TELL NURSE IF YOU ARE! ***

PRINT name as shown **EXACTLY** on Medicare Card: (if applicable)

NAME: _____ SEX: M F
FIRST MI LAST

DATE OF BIRTH: ____ / ____ / ____ PRIMARY PHONE #: ____ - ____ - ____
Month Day Year Age

STREET ADDRESS CITY STATE ZIP CODE

- I have read or have had explained to me the information in the Fact Sheet about the Emergency Use Authorization of the **Pfizer Covid-19 vaccine**. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the Covid-19 vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request.
- I, the undersigned, voluntarily agree to have the Covid-19 vaccine given to me (or the person named above). I have completed the pre-vaccination form. The person receiving this vaccine is in good health at this time and is not allergic to latex I understand that a physician consult is necessary prior to taking the vaccine for persons who have a history of bleeding disorder or on a blood thinner or have ever had a serious allergic reaction or other problems after getting any vaccination.
- I consent to allow information on this form, as well as the patient registration form, to be entered as necessary in the Illinois Immunization Registry (ICARE) and LCHD's electronic billing system.
- I have been provided information on V-Safe, a safety monitoring smartphone-based tool managed by CDC, and VaxText Messaging service for second-dose reminders.
- I will not hold the Douglas County Health Dept. or the nurse giving the vaccine responsible for any adverse reaction that may result from this vaccination.
- I authorize the release of any information necessary to process a Medicare, Medicaid or health insurance claim if applicable. I request payment of benefits to Douglas County Health Dept.
- I have been provided with Notice of Privacy Practices.

SIGNATURE: _____ DATE: _____

FOR NURSE USE ONLY: Fact Sheet Provided: ___ Yes ___ No

Vaccine Information: 2nd Dose Required: ___ Yes ___ No

Manufacturer: Pfizer Lot #: _____
Dosage: 0.3ml Expiration: _____

Site: Left Deltoid Right Deltoid

Nurse Signature: _____ Date/Time Administered: _____

For DCHD Use Only:
Name Printed Clearly by Employee/Volunteer: _____

Prevaccination Checklist for COVID-19 Vaccination



For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever received a dose of COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • If yes, which vaccine product(s) did you receive? <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another Product _____ • How many doses of COVID-19 vaccine have you received? _____ • Did you bring your vaccination record card or other documentation? 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? <i>(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had an allergic reaction to:			
<i>(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)</i>			
<ul style="list-style-type: none"> • A component of a COVID-19 vaccine, including either of the following: <ul style="list-style-type: none"> ○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures ○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids • A previous dose of COVID-19 vaccine 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had an allergic reaction to another vaccine <i>(other than COVID-19 vaccine)</i> or an injectable medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Check all that apply to you:			
<input type="checkbox"/> Am a male between ages 12 and 39 years old			
<input type="checkbox"/> Have a history of myocarditis or pericarditis			
<input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection			
<input type="checkbox"/> Have a bleeding disorder			
<input type="checkbox"/> Take a blood thinner			
<input type="checkbox"/> Have a history of Guillain-Barré Syndrome (GBS)			

Form reviewed by _____

Date _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists