COVID-19 Coronavirus

Douglas County Health Department

Print name as shown <u>EXACTLY</u> 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 **Moderna Covid-19 vaccine(Monovalent and Bivalent)**. 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:**_____

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

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?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product(s) did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	☐	☐	
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(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)*	☐	☐	☐
4. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	☐	☐	☐
5. Have you ever had an allergic reaction to: *(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.)*			
• A component of a COVID-19 vaccine, including either of the following:			
○ 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	☐	☐	☐
6. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(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.)*	☐	☐	☐

7. Check all that apply to you:

- ☐ Am a male between ages 12 and 39 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of Guillain-Barré Syndrome (GBS)

Form reviewed by _____ **Date** _____

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