H.C.H.D. Recipient Registration and COVID-19 Vaccine Administration Form

Recipient Full Name: _____
First Middle Last

Date of Birth: _____/_____/_____ Age in Years: _____

Recipient Email Address: _____ ☐ No email

Have you already registered in the COVID-19 Vaccine Portal? ☐ Yes ☐ No

Home Phone Number: _____ Mobile Phone Number: _____

Address: _____ City: _____

Zip Code: _____ County: _____ State: _____

Best way to contact you: ☐ SMS/Text Message ☐ Email ☐ Both ☐ None

Recipient Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown

Recipient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Recipient Gender: ☐ Male ☐ Female ☐ Other ☐ I do not want to specify

Preferred Language: ☐ English ☐ Vietnamese ☐ Arabic ☐ French ☐ Spanish ☐ Hindi ☐ Other ☐ Decline to state

Disabilities: ☐ Not Disabled ☐ Cancer ☐ Cognitive (Psychological or Psychiatric) ☐ Neurological
☐ Physical (Mobility) ☐ Respiratory ☐ Sensory (Vision or Hearing) ☐ Other (Please Specify: _____)

I certify that I am: (a) at least 18 years of age (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an 'applicable Provider'), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine.

Recipient Signature Statement of Understanding and Permission: I have read and I understand the information provided to me about receiving the COVID-19 vaccine and I have had the opportunity to ask questions. I have answered all questions on the attached CDC Prevaccination Checklist for COVID- 19 Vaccination. By signing below, I voluntarily give my permission for myself or for the recipient listed on this form (acting as responsible party) to receive a COVID-19 Vaccine. I understand no payments will be required from myself in regards to COVID-19 vaccination.

Notice of Privacy Practices: By signing below, I am also acknowledging that:
o The Notice of Privacy Practices for Harnett County Health Department has been made available to me.
o I understand that I may contact the person named in the notice if I have questions about the content of the notice.

X_____ x_____ x_____
Signature of Recipient/ Guardian Relationship Date

DO NOT WRITE BELOW THIS LINE

Circle Brand: Pfizer Moderna Janssen Novavax **Circle One:** MONOVALENT BIVALENT

Patient Dose: **1** **2** **3** **BOOSTER** **Lot Number:** _____

Injection Site: R Deltoid / L Deltoid / L Vastus Lateralis / R Vastus Lateralis

Dosage: Pfizer 0.3mL / Janssen 0.5mL / Moderna 0.5mL / Novavax 0.5mL

Pediatric Dosage: Pediatric Pfizer 6 months - 4 years 0.2mL / Pediatric Pfizer Ages 5-11 years old 0.2mL

Pediatric Moderna 6 months- 5 years 0.25mL / Pediatric Moderna 6 years -11 years 0.5mL

Patient Given COVID-19 Vaccination card, COVID-19 Vaccine EUA and V-Safe Information: Yes No

Administered by (sign & print):_____ **Date:**_____ **Time**:_____

If using minimum interval between first and second dose, choose reason: ☐ Moderately or Severely Immunocompromised ☐ 65 years and older ☐ Fullest protection needed to be achieved sooner (community levels/individual risk) ☐ Self- Attest Moderately-Severely Immunocompromised

Registered in CVMS: Yes No Administration Entered: Yes No

Revised 9.6.22

Prevaccination Checklist for COVID-19 Vaccination

Name _____

For vaccine recipients (both children and adults):

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

	Yes	No	Don't know
1. How old is the person to be vaccinated? _____			
2. Is the person to be vaccinated sick today?	☐	☐	☐
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product was administered? ☐ Pfizer-BioNTech ☐ Janssen *(Johnson & Johnson)* ☐ Another Product ☐ Moderna ☐ Novavax _____			
• How many doses of COVID-19 vaccine were administered? _____			
• Did you bring the vaccination record card or other documentation?	☐	☐	
4. Is the person to be vaccinated have a health condition or undergoing treatment that makes them moderately or severely immunocompromised? *This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.*	☐	☐	☐
5. Is the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. Has the person to be vaccinated 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	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. Has the person to be vaccinated 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.)*	☐	☐	☐

8. Check all that apply to the person to be vaccinated:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months?

Form reviewed by _____ **Date** _____