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:

- The Notice of Privacy Practices for Harnett County Health Department has been made available to me.
- 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

For Office Use Only: Circle one: **Pfizer Moderna Janssen** Circle one: **First Dose / Second Dose/ Third Dose/ Booster**

COVID-19 Vaccine Lot Number: _____ Injection Site (Circle one): **Right Deltoid / Left Deltoid**

Dosage: Pfizer 0.3mL / Janssen 0.5mL / Moderna 0.5mL or 0.25mL // Pediatric Pfizer Ages 5-11 years old 0.2mL

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

Administered by:_____ Date:_____Time:_____

Printed Name:_____**Registered in CVMS:** Yes No **Administration Entered:** Yes No

Revised 12-10-21

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:			
o Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
o 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 female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19
- ☐ 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 heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ Have a history of Guillain-Barré Syndrome (GBS)

Form reviewed by _____ **Date** _____

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