South Heartland District Health Department - COVID-19 VRAS Vaccine Registration Form

Last Name **First Name** **Date of Birth** **Age** **Doctor**

	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 did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• Did you bring your vaccination record card or other documentation? *(yes/no)*	☐	☐	
3. 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	☐	☐	☐
4. 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.)*	☐	☐	☐
5. Check all that apply to you:			

- ☐ Am a female between ages 18 and 49 years old
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer)
- ☐ Take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of herparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers

I have read and/or received a copy of the Emergency Use Authorization Fact Sheet for the COVID-19 vaccine administered today (Please check),

☐ Moderna 3.26.2021 ☐ Janssen J&J 04.23.2021 ☐ Pfizer 05.10.2021 ☐ Other _____

Recipient Signature OR Parent/Legal Guardian for recipient under age 19 Date

Vaccinator's Signature Date

SITE: Deltoid Rt Lt **DOSAGE:** **ROUTE: IM** **PLACE STICKER HERE: Vaccine Lot Number and Expiration Date**