Date:_____ Chart #: _____

Adolescent MCHD COVID Vaccination Form

Patient Legal Name: _____ **Date of Birth:** _____**Age:**_____

Address: _____**City:** _____**State:** _____**Zip:**_____

Phone: _____ **Gender:** ☐ Male ☐ Female

Race: ☐ White ☐ Asian ☐ Black/African American ☐ Native Alaskan/American Indian
☐ Native Hawaiian/Pacific Islander ☐ Prefer not to answer

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Prefer not to answer

Medical Screening Questionnaire & Consent for Vaccination

Has the person to be vaccinated ever received a dose of COVID-19 vaccine?

If yes, which vaccine product did they receive?

☐ Pfizer ☐ Another product: _____

Check if the person to be vaccinated has 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 them 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 OR flu vaccine, including either of the following:

- ☐ Polyethylene glycol (*PEG*), which is found in some medications, such as laxatives and preparation for colonoscopy procedures
- ☐ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids
- ☐ Egg

☐ A **previous allergic reaction** to a dose of COVID-19 vaccine

☐ A **previous allergic reaction** to the influenza vaccine

☐ A **previous allergic reaction -** Other -- Please describe: _____

Check all that apply to the person to be vaccinated:

- ☐ Are you feeling sick today?
- ☐ Have had a history of myocarditis or pericarditis
- ☐ 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
- ☐ History of Guillain-Barre syndrome (GBS)

I have read or have had explained to me the information in the vaccine information statement (VIS). I have also had a chance to ask any questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine.

Marquette County Health Department has made their Privacy Act practices available to me.

I authorize the release of any medical or other information with respect to this vaccine to Medicare, Medicaid or other third party payer as needed to request payment of authorized benefits to be made on my behalf to Marquette County Health Department. I acknowledge that if my insurance does not cover the cost of administering the vaccine then I will be responsible for any balance on my account for which I will receive a statement.

_____

Signature of Responsible Party **Date**

_____

Printed Name of Responsible Party **Phone (If different than above)**

THIS SIDE OF FORM TO BE COMPLETED BY MARQUETTE COUNTY HEALTH DEPT STAFF ONLY

Nurse Staff:_____ **Date Vaccine Administered:** _____

Vaccine	Manuf.	Lot #	Route	Dose	Site	Nurse Signature
COVID-19 Pfizer-BNT 10mcg	Pfizer		IM	0.2 mL	RD LD RT LT	
COVID-19 PFR 25 CTN or 195 CTN	Pfizer		IM	0.3 mL	RD LD RT LT	

Nurse Notes:

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