Randolph COVID Vaccine Administration Record (CVAR)

Janssen (JNJ)

Vaccine Dose # _____

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	Date of birth: * ____ ____ ____ Month Day Year	Age*	Sex: (Circle)* Male Female Other Prefer not to say
Street Address:*			
City:*	State: *	Zip:*	Phone:*
Email:*	Race:		Ethnicity:

Please answer the following questions:

1.) Is this your first dose or second dose of Covid-19? FIRST SECOND

2.) I am aware that I need to wait at least 15 to 30 minutes in the observation area after getting vaccinated. YES NO

3.) What is your Priority Group to get vaccinated today? (Please circle your choice below)

A. I am over 55 years of age or older.

B. I have 1 or more medical conditions that increase my risk for severe illness.

C. I live or work in low income and/or affordable senior housing.

D. I am a K-12 educators, K-12 school staff, or a child care worker

E. I am a Health care worker

F. I am a First Responder

G. I am helping someone that is 75 years of age or older get to the clinic to be vaccinated.

H. None of the above - I am a Randolph resident.

I consent to being vaccinated.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

BOH USE ONLY

Date of Service	Vax Type	Vax Mfgr	State Supplied (Circle)	Preserv Free*	Lot No	Exp Date	Dose (mL)	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given
	CoVID-19	J+J	Yes	Yes	043A21A	12/31 /69	0.5	IM	R Arm L Arm		

Provider Name: Randolph Board of Health MDPH Provider PIN#: 11380 Nurse Name: _____

Provider Address: 41 South Main St, Randolph, MA 02368 Signature: _____

Please turn over to complete Screening Questions on back page!

04-02-21 Ver.

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name _____

Age _____

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.

	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 ☐ Another product _____			
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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
• Polysorbate	☐	☐	☐
• 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	☐	☐	☐
6. Have you received any vaccine in the last 14 days?	☐	☐	☐
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
11. Are you pregnant or breastfeeding?	☐	☐	☐

Form reviewed by _____ **Date** _____

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