RFHN COVID-19 Vaccination Record

(affix label here)

Complete this section

Today's Date **Date of Birth***	**First Name** (Print)*	**Last Name** (Print)*	**Gender** (select one) * ☐ Female ☐ Decline to State ☐ Male ☐ Other

Mother's Maiden Name (for CAIR registration) **Ethnicity*** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Not Reported	**Race*** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Unknown/Not Reported	**Address** **County of Residence** **Phone**

COVID dose: ☐ 1st dose ☐ 2nd dose	**If 2nd dose, enter date and facility of 1st dose:**
COVID-19 Vaccine Screening Questionnaire completed (see other side of document)? ☐ Yes ☐ No	**COVID-19 Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS) received?** ☐ Yes ☐ No
Emergency Contact **Name:** **Relationship:** **Phone number:**	

* *Required information per CDC*

I have read or had explained to me the "COVID-19 Emergency Use Authorization (EUA) Fact Sheet." I have had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and request that it be given to me or to the person for whom I am authorized to make this request.

Patient Signature **Date**

TO BE COMPLETED BY INDIVIDUAL ADMINISTERING VACCINE

Date COVID-19 vaccine administered:	**Facility/Location:**	
COVID-19 Vaccine Screening Questionnaire reviewed and vaccination administration deemed appropriate: ☐ Yes ☐ No ☐ Precaution identified and vaccination in an alternate setting needed		
COVID dose: ☐ 1st dose ☐ 2nd dose	If 2nd dose, manufacturer of 1st dose:	
COVID-19 Vaccine Manufacturer: ☐ Moderna ☐ Novavax ☐ Pfizer ☐ Sanofi Pasteur ☐ Janssen (Johnson & Johnson)	**CVX:** **NDC:** **Lot Number:** **Expiration:**	**Injection volume:** ☐ 0.3mL ☐ 0.5mL Vial number:
Immunization site: ☐ Right Deltoid ☐ Right Thigh ☐ Left Deltoid ☐ Left Thigh	**Vaccine Information Statement (VIS) or Emergency Use Authorization (EUA) Fact Sheet date:**	**Administration time:**

Was today's vaccination administration successful? ☐ Yes ☐ No If no, is it possible to reattempt administration? ☐ Yes ☐ No	Was any vaccine wasted during administration? ☐ Yes ☐ No **If vaccine wasted select reason:** ☐ Broken Vial/Syringe ☐ Vaccine drawn but not administered ☐ Non-vaccine product (e.g. IG, HBIG, Dil) ☐ Open vial but all doses not administered ☐ Lost or unaccounted for vaccine ☐ Other:
If vaccination was unsuccessful select reason: ☐ Sick or fever ☐ Inventory Shortage ☐ No longer interested ☐ Other: ☐ Staffing ☐ Contraindication identified _____	
☐ COVID vaccine documentation completed in CAIR by (staff member signature):	

Signature and Title of Vaccinator **Date**

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 ☐ Janssen (Johnson & Johnson) ☐ 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 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			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
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?			
12. Do you have dermal fillers?			

Form reviewed by _____ **Date** _____