MASS COVID-19 CLINIC Vaccine Administration Record and Screening

Information collected on this form will be used to document authorization for receipt of vaccines. The information will be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and confidential. **Please Print.**

Patient's Name (Last, First, Middle Initial)			
Date of Birth (m/d/yyyy)	**Age**	**Gender** ☐Male ☐Female ☐Self-Identify	
Maiden Name or Other Last Names You've Had	**Telephone Number**		
Address	**City**	**State**	**Zip**
Ethnicity ☐ Hispanic ☐ Non-Hispanic	**Race** ☐Asian ☐Black/African American ☐Native American ☐Other Race ☐White		

Questions for person receiving vaccine	**Yes**	**No**
1. Are you sick today? (fever, cough, shortness of breath, nausea/vomiting in the last 24 hours)	☐	☐
2. Are you currently in your isolation or quarantine period due to COVID-19?	☐	☐
3. Have you ever had an observed anaphylactic reaction? If so, was it to a component of the COVID-19 vaccine, another vaccine, or an injectable (e.g., intramuscular, intravenous, or subcutaneous) therapy? **List:** *Please note, you will have to be observed for 30 minutes after receiving your vaccine	☐	☐
4. Have you ever received a dose of COVID-19 vaccine?	☐	☐
5. Have you received antibody therapy or convalescent plasma for COVID treatment in the past 90 days?	☐	☐
6. Have you received another vaccine in the past 14 days?	☐	☐
7. Are you immunocompromised or on a medication that affects your immune system?*	☐	☐
8. Are you pregnant or breastfeeding?*	☐	☐

I have been provided a copy and have read, or have had explained to me, information about the diseases and the vaccine to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of receiving a vaccine approved under an Emergency Use Authorization from the FDA.

I consent to receive the vaccine in a public location. I have been made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors. **I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me, or in the case that I am a guardian, my child**

Signature-Person to receive vaccine or person authorized to sign on the patient's behalf	**Date**
X	

FOR OFFICE USE ONLY

Is person receiving ☐ Dose 1 or ☐ Dose 2

Manufacturer: ____________________
Lot #: ______________________________
Expiration Date: _________________

Site of Injection: ☐ Right Deltoid ☐ Left Deltoid ☐ Other_________________________

Signature of Vaccine Administrator: ______________________________ **Date:** __________
Time:_______

DATA ENTRY into Wisconsin Immunization Registry

Date: _______________ Initials: __________