GREENDALE HEALTH DEPARTMENT **5650 Parking Street, Greendale, WI 53129**

MASS COVID-19 CLINIC Vaccine Administration Record and Screening

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 anyquestion, 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 the provider to explain it. Information collected on this form is voluntary and confidential. Please Print.

Client's Name (Last, First, Middle Initial)	Date of Birth (mm/dd/yyyy)	Age
Address, City, State, Zip Code	Email	Gender
Telephone Number	Race: African American Asian Caucasian Native American Other	
Mother's Maiden Name (Last, First, Middle Initial)	Ethnicity: Hispanic Non-Hispanic	

SCREENING QUESTIONS:	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 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.)		
4. Have you ever had an allergic reaction to a component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparationsfor colonoscopy procedures, Polysorbate, or a previous dose of COVID-19 vaccine? (This would include a severe allergic reaction.)		
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. Do you have a bleeding disorder or are you taking a blood thinner?		
8. Are you pregnant, breastfeeding or have a weakened immune system?		
9. Do you have dermal fillers?		
10. Have you ever received a dose of COVID-19 Vaccine: If yes; Pfizer or Moderna or Unknown		

I have been given a copy and have read/or have had explained to me the FDA Emergency Use Authorization Fact Sheet for the COVID-19 vaccine (the "fact sheet"). I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of this vaccine and ask that the vaccine be given to me or the person for whom I am authorized to make this request. I understand that two doses of the vaccine are recommended as described in the fact sheet. **I have been advised to wait for 15-30 minutes of observation after receiving my vaccine before leaving.**

Client/Parent / Guardian Signature:_____ **Date:**_____

Print Parent / Guardian Name, If Different from client:_____ **Date:**_____

******************For Clinic/Office Use******************

Vaccine	Route	Site of Injection	Dose #	Manufacturer	Lot Number Expires
COVID -19	IM	LD RD	1 2		

Signature of Vaccine Administrator **Title of Vaccine Administrator** **Date Vaccine Administered**