Covid Vaccine Administration Record and Screening Consent Form

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 healthcare providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary.

Last Name:	**First Name:**		**DOB:**
Phone:	**Email:**		
Social Security Number: (optional) will provide you access to your record	**City:**	**State:**	**Zip:**

Gender:
☐ Male ☐ Transgender – Male to Female ☐ Transgender – Unspecified or Gender Non-Specific
☐ Female ☐ Transgender – Female to Male ☐ Prefer not to Answer ☐ Other _____

Race: (check all that apply)
☐ Asian ☐ American Indian or Alaskan Native ☐ White
☐ African American or Black ☐ Native Hawaiian or other Pacific Islander
☐ Prefer not to Answer ☐ Other_____ ☐ Multi-race

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

Questions for person receiving vaccine	**Yes**	**No**
1. Are you sick today (fever, cough, shortness of breath, nausea/vomiting in the past 24 hours)		
2. Are you currently completing an isolation or quarantine due to COVID-19?		
3. Have you received a dose of COVID-19 vaccine?		
4. Have you ever had a severe allergic reaction (anaphylactic) to any food, medication, vaccine, or previous COVID-19 vaccine? List:		
5. Have you received antibody therapy of convalescent plasma for COVID-19 treatment in the past 90 days?		

I have been given a copy and have read, or have had explained to me, information about the disease 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 understand that if this vaccine requires two doses, two doses of this vaccine will need to be given in order for it to be effective. 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)_____Date_____

Relationship to recipient, if signing on recipient's behalf _____

Parent's name and Signature if a minor_____ Date:_____

For Vaccinator			
Vaccine	**Site**	**Signature and Title -- Person Administering Vaccine**	**Date**
COVID-19	**LD RD**		
Trade Name/Manufacturer Lot Number			