SARS-CoV-2/COVID-19 Vaccine Administration Record

_____	**Pfizer 12+**	**1st**	**2nd**	**3rd**	**Booster**	**Circle if**
_____	**Pfizer 5-11**	**1st**	**2nd**			**MINOR**
_____	**Moderna**	**1st**	**2nd**	**3rd**	**Booster**	
_____	**Johnson & Johnson**			**1st**	**Booster**	

PART A: PLEASE PRINT LEGIBLY & COMPLETE BOTH SIDES

Last Name: **First Name:** **M.I.:**

Address: **City:** **State:**

Zip Code: **Phone #:**

DOB: ____/____/_____ (MM/DD/YYYY) **Email:**

Race: AA/Black Asian Caucasian Hawaiian/Pacific Islander Native American
Multiple Other Declined

Ethnicity: Hispanic/Latino Non-Hispanic nor Latino Other Declined

Sex: Undifferentiated/Unknown Female Male Other

PART B: PLEASE READ AND CHECK YOUR ANSWER TO THE FOLLOWING QUESTIONS:

□ Yes □ No Are you currently experiencing symptoms consistent with COVID-19?
(Fever > 100°F, 37.7°C, cough, shortness of breath, fatigue, muscle or body aches, new loss of taste/smell, sore throat, congestion/runny nose, nausea/vomiting, diarrhea)

□ Yes □ No Have you ever experienced a severe reaction after receiving an injected medication?
(Swelling of the face, lips, tongue, throat; trouble breathing, wheezing)

PLEASE READ AND SIGN:

"I have read, or had explained to me, the information about the COVID-19 vaccine. I was given ample opportunity to ask questions and my questions have been answered satisfactorily. I believe I understand the benefits and risks of this vaccine and ask that the COVID-19 vaccine be given to me.

*For initial vaccinations, I understand that this is a one dose vaccine (J&J) **-OR-** a two-part vaccine series (Pfizer/Moderna) and agree to obtain my second dose.*

By signing below, I attest that I am eligible for initial and any additional doses of the COVID-19 vaccine based on the criteria specified by the Washington Department of Health (DOH)."

X_____ _____

RECIPIENT or LEGAL REPRESENTATIVE SIGNATURE **DATE**

PART C: *This portion to be completed by person administering the vaccine*

DATE GIVEN	SITE *(circle one)*	VACCINE MANUFACTURER	LOT NUMBER	EXPIRATION DATE
	L Deltoid / R Deltoid			

INITIALS OF VACCINE ADMINISTRATOR: _____ **2ND DOSE DUE**_____

8791-018187-1220

SARS-CoV-2/COVID-19 Vaccine Acknowledgment

By signing this form, I acknowledge the following:

- I have received, read, and understand the Vaccine Information Fact Sheet for Recipients and Caregivers provided by the Food and Drug Administration (FDA) or Centers for Disease Control (CDC) and/or the Emergency Use Authorization sheet corresponding to the COVID-19 vaccine that I am receiving.

- I know the Food and Drug Administration (FDA) has issued Emergency Use Authorization (EUA) of the Johnson & Johnson, Moderna, Pfizer 12-17, and Pfizer 5-11 vaccines; I know they are not a fully-licensed FDA vaccine. I know Pfizer 18+ has received full approval (BLA) from the FDA. I have had an opportunity to ask questions about the vaccines, and such questions were answered to my satisfaction. I now know about the vaccines, alternatives, benefits, and risks, to the extent they are known and unknown at this time. By signing this form, I hereby expressly request and authorize that the vaccine be administered to me.

- For initial Moderna and Pfizer vaccinations: I know that I must get two doses of the vaccines and I must receive the same vaccine each time. I know that if I do not get the second dose, the chance that I will become immune will go down. By signing this form, I agree to schedule and return for my second dose within the required timeframe.

- As with all vaccines, I understand that there is no guarantee that I will develop immunity to SARS-COV-2/COVID-19. I understand that I may experience side effects/immune response to the vaccine, as outlined on the aforementioned FDA or CDC vaccine information statement(s) for the COVID-19 vaccine that I am receiving.

- I agree to stay in the designated waiting area for 15 minutes after receiving my vaccination to ensure that no immediate reactions occur. I know that if I have a severe allergic reaction after leaving the designated waiting area, including difficulty breathing, swelling of my face and/or throat, a fast heartbeat, a bad rash, dizziness or weakness, I should call 9-1-1 or go to the nearest hospital. I understand that if I have any other side effects, it is my responsibility to discuss such side effects with my physician at my expense.

- I understand that Island County Public Health may be required to or may voluntarily disclose my vaccine-related health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also understand that Island County Public Health will use and disclose my health information as described in its Notice of Privacy Practices which I may receive upon request or find on its website.

- I agree to receive communications from employees and/or agents of Island County Public Health and/or the Washington Department of Health in the form of phone calls, text messages, emails and/or letters concerning this vaccination and subsequent doses.

_____ Date_____

Signature of Patient **OR** Legal Representative

_____ _____ Date_____

Relationship to Patient, if signed by legal representative Signature of Witness

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