SARS-CoV-2/COVID-19 Vaccine Administration Record	AND COUNT								
Pfizer 12+       1st       2nd       3rd       Booster       Circle if         Prizer 5-11       1st       2nd       MiNOR         Moderna       1st       2nd       3rd       Booster         Johnson & Johnson       1st       2nd       3rd       Booster         PART A: PLEASE PRINT LEGIBLY & COMPLETE BOTH SIDES       Image: Mile       Mile         Last Name:       First Name:       Mil:         Address:       City:       State:         Zip Code:       Phone #:       DOE:         DOE:       // (MM/DD/YYYY)       Email:         Race:       AA/Black       Asian         Multiple       Other       Declined         Ethnicity:       Hispanic/Latino       Non-Hispanic nor Latino       Other         PART B: PLEASE READ AND CHECK YOUR ANSWER TO THE FOLLOWING QUESTIONS:       Part B: PLEASE READ AND CHECK YOUR ANSWER TO THE FOLLOWING QUESTIONS:         If Yes       INO       Are you currently experiencing symptoms consistent with COVID-19?       (Fever > 100°F, 37.7°C, cough, shortness of breath, faigue, muscle or body aches, new loss of tasks/smell, sore throat, congestion/unny nose, nausea/onling, diarthea)         If Yes       INO       Have you ever experienced a severe reaction after receiving an injected medication?         (Swelling of the face, lips, tongue,	ISLAND COUNT)	SAPS-CoV-		Vaccin	o Adr	ninistrati	ion Pocc	ord	
Prizer 5-11 1 1st 2nd MiNOR     MiNOR     Moderna 1st 2nd 3rd Booster     Johnson & Johnson 1st Booster  PART A: PLEASE PRINT LEGIBLY & COMPLETE BOTH SIDES Last Name: MIL:     Address: City: State:     Zip Code: Phone #:     DOB: / / (MM/DD/YYY) Email:     Racce: 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, failgue, muscle or body aches, new loss     of laste/smell, sore throat, congestion/funny nose, neusee/vontiling, diambea)     Yes No Have you ever experiencing symptoms consistent with COVID-19?     (Fever > 100°F, 37.7°C, cough, shortness of breath, failgue, muscle or body aches, new loss     of laste/smell, sore throat, congestion/funny nose, neusee/vontiling, diambea)     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:     Theve 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/Moderma) 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 Heattin (DOH).*     X     RECIPIENT or LEGAL REPRESENTATIVE SIGNATURE     DATE  PART C: 'This portion to be completed by person administering		<u>3AK3-COV-</u>		Vacui	le Aul	iiiii5iiai			
Moderna       1st       2nd       3rd       Booster	Contraction of the second seco	Pfizer	12+ 1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	Boost	er	Circle if	
Johnson & Johnson 1 <sup>st</sup> Booster PART A: PLEASE PRINT LEGIBLY & COMPLETE BOTH SIDES Last Name:     First Name:     Kil;     State:     Zip Code:     Phone #: DOB: / / (MMDD/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 I No Are you currently experiencing symptoms consistent with COVID-19?     ( <i>Fever</i> > 100°F, 37.7°C, cough, shortness of breath, fatigue, muscle or body aches, new loss of task/smell, sore throat, congestion/numy nose, nausea/vomiling, diarthea)     Yes I No Have you ever experienced a severe reaction after receiving an injected medication?     ( <i>Swelling of the face, lips, tongue, throat; trouble breathing, wheezing</i> ) 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. Eor initial vaccinations, I understand that this is a one dose vaccine (J&J) -OR- a two-part vaccine based on the criteria specified by the Washington Department of Health (DOH)."     RECIPIENT or LEGAL REPRESENTATIVE SIGNATURE DATE     DATE PART G: 'This portion to be completed by person administering the vaccine'     L Deltoid / R Deltoid     L Deltoid / R Deltoid	PUBLIC HEALT	Pfizer	5-11 1 <sup>st</sup>	2 <sup>nd</sup>				MINOR	
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## 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 vaccinerelated 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.

Signature of Patient <b>OR</b> Legal Representative		_ Date
Relationship to Patient, if signed by legal representative	Signature of Witness	_ Date
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