# COVID-19 Screening and Vaccine Administration Record

***PLEASE PRINT:***

**Last Name: _____First Name: _____Date of Birth: _____Age:_____**

**Employer: _____NA_____Email Address: _____Phone Number: _____**

**Address: _____**

| **PLEASE ANSWER THESE QUESTIONS** | **YES** | **NO** |
|---|---|---|
| 1. Have you received previous dose(s) of the COVID-19 vaccine? | | |
| a. If yes, Date and manufacturer of previous dose #1_____ #2_____ | | |
| b. If yes, did you experience an allergic reaction after the vaccine (hives, angioedema, respiratory distress (e.g., wheezing, stridor), facial/lip swelling)? | | |
| 2. Are you under the age of 18? (*If you are under 18 you must have a parental consent to receive vaccine. Pfizer can be given to those 12 and older; Moderna and Janssen can be given to those 18 and older.)* | | |
| 3. Are you currently on quarantine due to an exposure to COVID-19? | | |
| 4. Are you currently on isolation due to being diagnosed with COVID-19 in the last 10 days? | | |
| 5. Have you received monoclonal antibodies or convalescent plasma in the last 90 days for the treatment of COVID-19? | | |
| 6. Have you had a serious allergic reaction or anaphylaxis due to ANY cause (food, medications, bees, etc.) | | |
| 7. Do you have an allergy to polyethylene glycol (PEG), polysorbate or a component of the vaccine? (Refer to the respective EUA or other applicable FDA Fact Sheet of the Pfizer, Moderna, or Janssen COVID-19 vaccines.) | | |
| 8. Have you had an allergic reaction or anaphylaxis to a prior vaccine or other injectable medicine (intravenous, subcutaneous, or intramuscular)? | | |
| 9. Are you pregnant or breastfeeding? | | |
| a. If yes, have you discussed and received counseling regarding COVID-19 vaccination from your Physician? | | |
| 10. Do you have HIV, other immunocompromising conditions or take immunosuppressive medication or therapies? | | |
| a. If yes, have you discussed and received counseling regarding COVID-19 vaccination from your Physician | | |

I received and read the Emergency Use Authorization or other applicable fact sheet information regarding the possible side effects, risks and contraindications of the COVID-19 vaccine. Avera will disclose this immunization to the appropriate State Immunization Registry Database.

If the named individual is under the age of 18, as parent or guardian I acknowledge receipt of the Emergency Use Authorization or other applicable and consent to have the Pfizer vaccine administered to him/her.

Parent/Guardian: _____

**ADMINISTRATIVE USE ONLY:**

| Vaccine: COVID-19 | Please circle one: Pfizer – BioNTech COVID -19 Vaccine | Moderna COVID-19 Vaccine | Janssen COVID-19 Vaccine |
|---|---|---|---|
| Date & Time Vaccine Administered: | Vaccine Manufacturer/Lot Number/Expiration Date: | Site: | Signature & Title of Vaccine Administrator: |
| | | IM Deltoid: Location (circle one) Left Right | AMG Dell Rapids |

Observation Time (circle one): 15 minutes 30 minutes