☐ **Moderna Monovalent** ☐ **Pfizer Monovalent** **6 months – 4years**

Covid-19 Vaccine-English

Cass County Health Department

DATE OF BIRTH

_____ _____ ____ _____ ___/___/___ ____

Patient Name (Last) **First** **MI** **Phone** **mm / dd / yy** **Age**

_____ **Sex** ☐ **Male** ☐ **Female**

Address **City** **State** **Zip Code**

Ethnicity	☐ Not Hispanic / Not Latino	**Race**	☐ American Indian/Alaska Native	☐ Asian
	☐ Hispanic / Latino		☐ Black/African American	☐ White
	☐ Unknown / Not Reported		☐ More than one race	☐ Native Hawaiian
			☐ Other Pacific Islander	☐ Declined

Legal Guardian/Parent Name:_____ **Phone:**_____

Name of Insurance_____ ☐**No Health Insurance**

Policy / ID#_____ **Group#**_____

Is your child feeling sick today? *Contraindicated if fever or acute serious illness	**Yes**	**No**	**Unknown**
Has your child ever received a dose of COVID vaccine? Type:_____ **Date:**_____ **Received at CCHD? Yes** ☐ **No** ☐	**Yes**	**No**	**Unknown**
Has your child completed a two dose series of the Covid-19 Vaccine? **Type:**_____ **Date of Completion:**_____ **Received at CCHD? Yes** ☐ **No** ☐	**Yes**	**No**	**Unknown**
Has your child received a third dose of the Covid-19 Vaccine? **Type:**_____ **Date of Completion:** _____ **Received at CCHD? Yes** ☐ **No** ☐	**Yes**	**No**	**Unknown**
Has your child ever had a severe reaction (anaphylaxis) to something? ***Must monitor for 30 minutes post vaccination**	**Yes**	**No**	**Unknown**
Was the severe reaction after a COVID -19 vaccine? ***Contraindicated-refer to allergist / immunologist**	**Yes**	**No**	**Unknown**
Was the severe reaction after receiving another vaccine or another injectable medication? *Contraindicated-refer to allergist / immunologist	**Yes**	**No**	**Unknown**
Is your child currently placed under quarantine/isolation?	**Yes**	**No**	**Unknown**
Does your child have a weakened immune system or does your child take immunosuppressive drugs or therapies? ***Immunocompromised persons, including individuals receiving immunosuppressant therapy, may have a diminished immune response to the COVID-19 Vaccine.**	**Yes**	**No**	**Unknown**
Does your child have a bleeding disorder or is your child taking a blood thinner? ***23G or smaller needle and firm pressure for two or more minutes**	**Yes**	**No**	**Unknown**
Has your child fainted after receiving an injection?	**Yes**	**No**	**Unknown**
Has your child developed pericarditis/myocarditis after receiving an mRNA vaccine? (Contraindicated)	**Yes**	**No**	**Unknown**
Does your child have a history of pericarditis/myocarditis within 3 weeks after any COVID-19 vaccine?	**Yes**	**No**	**Unknown**
Has your child ever been diagnosed with MIS-C or MIS-A (Multisystem inflammatory syndrome)?	**Yes**	**No**	**Unknown**

I give my permission to Cass County Health Department (CCHD) to provide services to my child. I authorize payment of Medicaid/ AllKIDS/ Medicare/ Private Insurance benefits to CCHD for services rendered. I acknowledge that I have read and understand the possible side effects as described in the CDC Vaccine Information Sheets and Fact Sheet for Recipients and Caregivers.

I give permission for my child to receive vaccine(s).

Signature:_____ **Date:** _____

Printed name of Parent/Guardian: _____

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Covid-19 Vaccine-English

Cass County Health Department

*****Office use only below this line*****									
Vaccine	**Dose**	**Route**	**Deltoid**	**Thigh**	**Dose**	**Source**	**Lot#**	**EXP Date**	**VIS Pub Date**
MODERNA Covid-19 (6 months - 4 years) See CDC Standing Orders for administration guidelines	0.25 mL	IM	Right Left	Right Left	1st 2nd 3rd Booster	F S P			
PFIZER Covid-19 (6 months -4 years) See CDC Standing Orders for administration guidelines	0.3 mL	IM	Right Left	Right Left	1st 2nd 3rd Booster	F S P			
Nurse Signature:_____ **Date:**_____ **Adm. Time:**_____									

Form Reviewed By/Vaccine Administered By: Location:_____

Ser vice given per☐ CCHD Standing Order/EUA☐ Other:_____ Entered into ICARE:_____ Date:_____