☐ MODERNA ☐ PFIZER

Cass County Health Department Bivalent COVID-19 Vaccine Booster

DATE OF BIRTH

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

Address **City** **State** **Zip Code** **Sex ☐ Male ☐ Female**

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

Emergency Contact Name: **Phone:**

Name of Insurance **☐No Health Insurance**

Policy / ID# **Group#**

Are you feeling sick today? *Contraindicated if fever or acute serious illness	**Yes**	**No**	**Unknown**
Have you ever received a dose of COVID vaccine? Type: Date: **Received at CCHD? Yes ☐ No ☐**	**Yes**	**No**	**Unknown**
Have you completed a two dose series of the Covid-19 Vaccine? Type: Date of Completion: Received at CCHD? Yes ☐ No ☐	**Yes**	**No**	**Unknown**
Have you completed a third dose of a Covid-19 vaccine? Type: Date of completion: Received at CCHD? Yes ☐ No ☐	**Yes**	**No**	**Unknown**
Have you received any booster doses? Type: Date of Completion: Received at CCHD? Yes ☐ No ☐	**Yes**	**No**	**Unknown**
Have you 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**
Are you currently placed under quarantine?	**Yes**	**No**	**Unknown**
Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	**Yes**	**No**	**Unknown**
Do you have a weakened immune system or do you 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**
Do you have a bleeding disorder or are you taking a blood thinner? *23G or smaller needle and firm pressure for two or more minutes	**Yes**	**No**	**Unknown**
Are you pregnant or breastfeeding? *Must have prescription from your obstetrician	**Yes**	**No**	**Unknown**
Do you have a history of pericarditis/myocarditis? *If yes, a note from physician with approval to receive vaccine must be provided.	**Yes**	**No**	**Unknown**
Have you 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 me. 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 myself or my child to receive vaccine(s).

Signature: **Date:**

Printed name of Parent/Guardian:

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*****Office use only below this line*****									
Vaccine	**Dose**	**Route**	**Deltoid**	**Thigh**	**Dose**	**Source**	**Lot#**	**EXP Date**	**VIS Pub Date**
MODERNA Bivalent COVID-19 Vaccine Booster *18 years and up *May receive 2 months after completion of a primary series of any Covid-19 Vaccine *May receive 2 months after completion of last booster dose of any previously authorized or approved Covid-19 booster vaccine and Moderna Covid-19 Vaccine	0.5 ml	IM	Right Left	Right Left	**Booster** 1st	F S P			
PFIZER Bivalent COVID-19 Vaccine Booster *****12 years and up *May receive 2 months after completion of a primary series of any Covid-19 Vaccine *May receive 2 months after completion of last booster dose of any previously authorized or approved Covid-19 booster vaccine and Moderna Covid-19 Vaccine	0.3 ml	IM	Right Left	Right Left	**Booster** 1st	F S P			
Nurse Signature:_____ **Date:**_____ **Adm. Time:**_____									

Form Reviewed By / Vaccine Administered By
Service given per ☐CCHD Standing Order / EUA ☐Other_____

Location_____
Entered into ICARE:_____Date:_____

Moderna: COVID-19 vaccination should not be deferred in patients who received monoclonal antibody treatment or convalescent plasma. Patients should delay taking **EVUSHELD** for two weeks after COVID-19 vaccination.