☐ **MODERNA** ☐ **PFIZER**

Cass County Health Department COVID-19 Vaccine

DATE OF BIRTH

______________________ ____________________ ____ ______________________ ___/___/___ ____

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

____ **Sex** ☐ **Male** ☐ **Female**

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

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

Emergency Contact Name:_________________________________**Phone:**______________________

Name of Insurance_________________________________ ☐**No Health Insurance**

Policy / ID#______________________________**Group#**____________________________________

Question			
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 your first booster dose? **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: ______________________________

☐ **MODERNA** ☐ **PFIZER**

Cass County Health Department COVID-19 Vaccine

*****Office use only below this line*****									
Vaccine	**Dose**	**Route**	**Deltoid**	**Thigh**	**Dose**	**Source**	**Lot#**	**EXP Date**	**VIS Pub Date**
MODERNA Covid-19 (12 and older) *Moderna second dose at 28 days or later *Moderna/Pfizer third dose 28 days or later	0.5 ml	IM	Right Left	Right Left	**Primary Series** 1st 2nd 3rd	F S P			
MODERNA Covid-19 (6-11) *Moderna second dose at 28 days or later	0.5 ml	IM	Right Left	Right Left	**Primary Series** 1st 2nd 3rd	F S P			
PFIZER Covid-19 Vaccine(12 and older) *Pfizer second dose at 21 days or later *Moderna/Pfizer third dose 28 days or later	0.3 ml	IM	Right Left	Right Left	**Primary Series** 1st 2nd 3rd	F S P			
PFIZER Covid-19 Vaccine (5-11) *Pfizer third dose 28 days or later from 2nd dose (for ages 5-11) that are immunocompromised)	0.2 ml	IM	Right Left	Right Left	**Primary Series** 1st 2nd 3rd	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:____________