☐ MODERNA ☐ PFIZER

Cass County Health Department COVID-19 Vaccine

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 ☐ Hispanic / Latino ☐ Unknown / Not Reported	Race	☐ American Indian/Alaska Native ☐ Black/African American ☐ More than one race ☐ Other Pacific Islander	☐ Asian ☐ White ☐ Native Hawaiian ☐ 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:____________	Yes	No	Unknown
Have you completed a two dose series of the Covid-19 Vaccine? Type:____________Date of Completion:____________	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
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? *Contraindicated if less than 90 days prior to today	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

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 my permission to have the vaccine(s). Signature ☒____________________

Printed name of Parent/Guardian ☒____________________

************Office use only below this line*************

Vaccine	Dose	Route	Deltoid	Dose	Source*	Lot#	EXP Date	VIS Pub Date
MODERNA Covid-19 Vaccine	0.5ml	IM	Right Left	1st 2nd 3rd	F S P			
PFIZER Covid-19 Vaccine	0.3ml	IM	Right Left	1st 2nd 3rd	F S P			

Nurse Signature:____________________ **Date:**__________ **Adm.Time:**__________

Form Reviewed By / Vaccine Administered By Location____________________

Service given per ☐CCHD Standing Order / EUA ☐Other____ Entered into ICARE: __________Date:__________

*Moderna second dose at 28 days or later *Pfizer second dose at 21 days or later*Moderna/Pfizer third dose 28 days later