☐ **Moderna Monovalent** ☐ **Pfizer Monovalent** **5 years and older**

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#**

Are you or your child feeling sick today? *Contraindicated if fever or acute serious illness	**Yes**	**No**	**Unknown**
Have you/your child ever received a dose of COVID vaccine? Type: Date: **Received at CCHD? Yes ☐ No ☐**	**Yes**	**No**	**Unknown**
Have you/your child completed a two dose series of the Covid-19 Vaccine? **Type: Date of Completion: Received at CCHD? Yes ☐ No ☐**	**Yes**	**No**	**Unknown**
Have you/your child received a third dose of the Covid-19 Vaccine? **Type: Date of Completion: Received at CCHD? Yes ☐ No ☐**	**Yes**	**No**	**Unknown**
Have you/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**
Are you or your child currently placed under quarantine/isolation?	**Yes**	**No**	**Unknown**
Do you/your child have a weakened immune system or do you/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**
Do you/your child 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**
Have you/your child fainted after receiving an injection?	**Yes**	**No**	**Unknown**
Have you/your child developed pericarditis/myocarditis after receiving an mRNA vaccine? (Contraindicated)	**Yes**	**No**	**Unknown**
Do you/your child have a history of pericarditis/myocarditis within 3 weeks after any COVID-19 vaccine?	**Yes**	**No**	**Unknown**
Have you/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 me/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 myself or my child to receive vaccine(s).

Signature: **Date:**

Printed name of Parent/Guardian:

☐ **Moderna Monovalent** ☐ **Pfizer Monovalent** **5 years and older**

Covid-19 Vaccine-English

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*****Office use only below this line*****									
Vaccine	**Dose**	**Route**	**Deltoid**	**Thigh**	**Dose**	**Source**	**Lot#**	**EXP Date**	**VIS Pub Date**
MODERNA Monovalent Covid-19 (5 years and older) 2023-24 formula See CDC Standing Orders for administration guidelines	0.25 ml Single dose-dark blue cap green label 0.50 ml Single dose vial dark blue cap/blue label or manufacturer filled with dark blue box on label	IM	Right Left	Right Left	1st 2nd 3rd Booster	F S P			
PFIZER Monovalent Covid-19 (5 years and older) 2023-24 formula 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:_____

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