Columbia County Division of Health
111 E Mullett ST
Portage, WI 53901

COVID-19 VACCINE ADMINISTRATION RECORD

Information collected on this form will be used to document authorization for receipt of the COVID-19 Vaccine. Information may be shared through the Wisconsin Immunization Registry (WIR) and other health care providers directly involved with the patient to assure completion of the vaccine schedule.

PLEASE PRINT CLEARLY

Last:	First:	Middle:	*Date of Birth (mm-dd-yyyy)* - - *Age* _______
Street Address:			Gender ☐ Male ☐Female ☐ Other

City	State	Zip Code	Telephone Number ( )

Race (Check One)
☐Native American or Alaska Native ☐Other ☐Native Hawaiian or Other Pacific Islander
☐Asian ☐White ☐Black or African American

Ethnicity (check one)
☐Hispanic
☐Non-Hispanic

Mother's Maiden Name (Last, First) (used to help verify client record)	Social Security Number (used to access the Wisconsin Immunization Registry)

The following questions will help us to determine if there is any reason we should not give you injectable COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means that additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

☐ Yes ☐ No Are you feeling sick today (fever, cough, shortness of breath, nausea/vomiting in last 24 hours)?

☐ Yes ☐ No Have you ever had a severe allergic reaction (anaphylaxis) to anything, including food, medicine, vaccines, injectable therapy, polyethelene glycol, or polysorbate? Describe:_________________________________

☐ Yes ☐ No Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?

☐ Yes ☐ No Have you received another vaccine in the last 14 days?

☐ Yes ☐ No Are you currently in your isolation or quarantine period due to COVID-19?

I have been given a copy and have read, or have had explained to me, a copy of the FDA Emergency Use Authorization Fact Sheet for COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of receiving a vaccine approved under an Emergency Use Authorization from the FDA. I consent to receive the vaccine in a public location. I have been made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors (15 or 30 minutes). **I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me, or in the case that I am a guardian, my child.**

I consent to receiving this vaccination. I waive all claims against the Columbia County Health and Human Services that may be associated with my receipt of this vaccination, and I assume all risk(s) associated in receiving such vaccination. ☐ Yes ☐ No

If I should suffer a severe reaction to my vaccination, I consent to the administration of epinephrine and/or other emergent medical treatment necessary. ☐ Yes ☐ No

SIGNATURE: Person to receive vaccine or person authorized to sign on the patient's behalf **DATE:**
X____ ____________________________

Date of administration: ______________________________ **Manufacturer:** _____________________ **Lot #:** _________________________

Dose: #1 #2 **IM Route:** RD LD **Vaccinator Signature and Title:** ____

Entered into WIR: ____________________