COVID-19 Vaccine Registration and Administration Form

Vaccine Recipient Information

Last Name: _____ M.I. _____ First Name: _____

Date of Birth: _____/_____/_____ ___Male ___Female Phone: _____ Please circle dose: 1st 2nd 3rd

Address: _____ City/State: _____ Zip Code: _____

Race (Please Circle): White Black/African American Asian Native HI/Other Pacific Islander American Indian/AK Native Other

Hispanic (Please Circle): Yes No

Name of Emergency Contact: _____ Phone: _____

1	Are you feeling sick today?		Yes	No	Unsure
2	Have you been named as a close contact to a COVID-19 case in the past 10 days?		Yes	No	Unsure
3	Have you ever received a dose of COVID-19 vaccine?		Yes	No	Unsure
3a	If you have received a dose of COVID-19 vaccine, which vaccine product did you receive?	Pfizer Moderna	Johnson & Johnson		Other
3b	Did you bring your vaccination record card or other documentation?		Yes	No	Unsure
4	Do you have any allergies to medications, food, a vaccine component, or latex? If yes, please list:		Yes	No	Unsure
5	Do you have allergies to a component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures.		Yes	No	Unsure
6	Do you have allergies to polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids?		Yes	No	Unsure

Mark all conditions that apply to you:			
	Am a female between ages 18 and 49 years old		Have a bleeding disorder
	Am a male between ages 12 and 29 years old		Take a blood thinner
	Have a history of myocarditis or pericarditis		Have a history of heparin-induced thrombocytopenia
	Had COVID-19 and was treated with monoclonal antibodies or convalescent serum within last 90 days		Am currently pregnant or breastfeeding
	Diagnosed with Multisystem inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection		Have received dermal fillers
	Have a weakened immune system (i.e, HIV, cancer) or take immunosuppressive drugs or therapies		History of Guillain-Barre Syndrome (GBS)

Emergency Use Authorization (EUA) Information:

Flathead City-County Health Department was chosen as a Point of Dispensing (POD) organization in Montana for COVID-19 vaccine. The COVID-19 vaccine was granted emergency use authorization by the Federal Drug Association (FDA). The Centers for Disease Control and Prevention (CDC) has determined a phased-approach distribution with healthcare workers and first responders as the first phase. No vaccination information sheet will be available for this vaccine until after the vaccine has gone through full licensure.

COVID-19 Vaccine Side Effect Information:

Common side effects of the COVID-19 vaccine include soreness at injection site, chills, headache, general aches, mild flu-like symptoms, and low-grade fever. If you experience these side effects, they will usually subside in 2 to 3 days. If you experience these side effects, it is still recommended to receive the 2nd dose of the COVID-19 vaccine.

You cannot get COVID-19 from the COVID-19 vaccine, however it is possible that you were exposed prior to being vaccinated and you had not yet developed symptoms. If you begin to experience any of the following symptoms of COVID-19, please contact your primary care provider—cough, loss of taste or smell, sore throat, severe body ache. Also contact your primary care provider if you experience gland swelling, fast heartbeat, trouble breathing, or allergic reaction.

Vaccine Adverse Event Reporting System:

Anyone can submit information to VAERS to report any potential side effects or adverse reactions to a vaccine received. To submit the report, please go to the following link and follow the prompts: https://vaers.hhs.gov/reportevent.html

Second-Dose Question: Did you experience any side effects with the first dose administration? __ Yes __ No __ Not Applicable

Mandated data entry into ImMTrax:

Documentation of the administration of both doses of the COVID-19 vaccine will be entered into your electronic medical record and is mandated to be entered into the Montana Immunization Registry (ImMTrax), regardless of your preferences for other immunization data. By signing below, you are acknowledging that you are aware of this mandatory reporting element and approve receiving phone calls or text messages related to appointment reminders.

_____ _____

Signature Date

Manufacturer	Dose	Lot #	Route	Site	Nurse Initials	Return Date
__Pfizer __Moderna __Janssen			IM	Deltoid __L __R		