COVID-19 Vaccination Form
Complete all Highlighted Areas

Greene County Health Department
310 Fifth Street, Carrollton, IL 62016

Demographics

Name:
Last: _____ First: _____ M.I.: _____ Date of Birth: ___/___/___ Age: ___

Race: _____ Hispanic/Latino: Y N Sex: M F Employer: _____ SSN:_____

Address: _____ City: _____ Zip: _____

Phone: _____ Physician:_____ County: _____

PAY SOURCE – SELECT PRIMARY PAYER (Only select one):

☐ Uninsured
☐ Medicare ID #: _____
☐ Medicaid Insurance Company: _____ Member ID #: _____
☐ Commercial Insurance Company: _____ Member ID #: _____
Policy Holder Name: _____ Group #: _____

HIPAA

Put an "X" in the box below to indicate that you have the HIPAA and EUA information.

☐ **HIPAA** – I understand a *Notice of Privacy Practices* is available at my request. Under the Healthcare Insurance Portability and Accountability Act, I authorize to disclose my Immunization Record to my physician, ICARE, school, employer or other: _____

☐ **I have received/read the Emergency Use Authorization (EUA) Packet**

Screening Checklist for Contraindications to the COVID-19 Vaccination

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

	Yes	No	Not Sure
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Other_____			
3. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something?	☐	☐	☐
Example: A reaction which you were treated with epinephrine, EpiPen or which you had to go to the hospital?			
- Was the severe allergic reaction after receiving a COVID19 vaccine?	☐	☐	☐
- Was the severe allergic reaction after receiving another vaccine or another Injectable medication?	☐	☐	☐
4. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
5. Have you received passive antibody therapy as treatment for COVID-19?	☐	☐	☐
6. Have you had a vaccine in the last 14 days?	☐	☐	☐

"I have completed this form to the best of my knowledge. I have been given, read and understand the possible side effects described in the Vaccine Information Statement (VIS) that could be caused by the vaccine. I give my consent for vaccine to be administered as indicated. The Greene County Health Department does not charge for this vaccine but reserves the right to bill insurance providers for administrative fees.

Signature: _____ **Date**: _____
(Client or guardian must sign)

Vaccine Administered ***for office use only***

Vaccine Administered Date – Vial – T/TP – T/T-M – Lot – Exp. Date	Time/Temp Administered	Injection Site/Route	EUA/VIS Date
		RA/LA IM	**Pfizer 6/21 Moderna 6/21 JJ 7/21**

Staff Monitoring Vial Time/Temp Pulled: _____ Date: _____

Nurse reviewing form and giving vaccine: _____ Date: _____