



COVID-19 Screening and Vaccine Administration Record

PLEASE PRINT:

Last Name: _____ First Name: _____ Date of Birth: _____ Age: _____

Employer: _____ Email Address: _____ Phone Number: _____

Address: _____

PLEASE ANSWER THESE QUESTIONS	YES	NO
1. Have you received previous dose(s) of the COVID-19 vaccine? a. If yes, Date and manufacturer of previous dose #1 _____ #2 _____		
b. If yes, did you experience an allergic reaction after the vaccine (hives, angioedema, respiratory distress (e.g., wheezing, stridor), facial/lip swelling)?		
2. Are you under the age of 18? (If you are under 18 you must have a parental consent to receive vaccine. Pfizer can be given to those 12 and older; Moderna and Janssen can be given to those 18 and older.)		
3. Are you currently on quarantine due to an exposure to COVID-19?		
4. Are you currently on isolation due to being diagnosed with COVID-19 in the last 10 days?		
5. Have you received monoclonal antibodies or convalescent plasma in the last 90 days for the treatment of COVID-19?		
6. Have you had a serious allergic reaction or anaphylaxis due to ANY cause (food, medications, bees, etc.)		
7. Do you have an allergy to polyethylene glycol (PEG), polysorbate or a component of the vaccine? (Refer to the respective EUA or other applicable FDA Fact Sheet of the Pfizer, Moderna, or Janssen COVID-19 vaccines.)		
8. Have you had an allergic reaction or anaphylaxis to a prior vaccine or other injectable medicine (intravenous, subcutaneous, or intramuscular)?		
9. Are you pregnant or breastfeeding? a. If yes, have you discussed and received counseling regarding COVID-19 vaccination from your Physician?		
10. Do you have HIV, other immunocompromising conditions or take immunosuppressive medication or therapies? a. If yes, have you discussed and received counseling regarding COVID-19 vaccination from your Physician		

I received and read the Emergency Use Authorization or other applicable fact sheet information regarding the possible side effects, risks and contraindications of the COVID-19 vaccine. Avera will disclose this immunization to the appropriate State Immunization Registry Database.

If the named individual is under the age of 18, as parent or guardian I acknowledge receipt of the Emergency Use Authorization or other applicable and consent to have the Pfizer vaccine administered to him/her.

Parent/Guardian: _____

ADMINISTRATIVE USE ONLY:

Vaccine: COVID-19	Please circle one: Pfizer – BioNTech COVID -19 Vaccine Moderna COVID-19 Vaccine Janssen COVID-19 Vaccine		
Date & Time Vaccine Administered:	Vaccine Manufacturer/Lot Number/Expiration Date:	Site:	Signature & Title of Vaccine Administrator:
		IM Deltoid: Location (circle one) Left Right	

Observation Time (circle one): 15 minutes 30 minutes