Nemaha County Community Health Services

COVID-19 VACCINE ADMINISTRATION RECORD

PATIENT INFORMATION

Name _____ **Age**_____ **DOB** _____ **Sex:** Male Female
(First) (Last) (MI) (Date of Birth)

Mailing Address _____ **City** _____ **State** ____ **Zip Code** _____

Phone Number _____ **Primary Care Physician:** _____

I have been given a copy and have read, or had explained to me, the information in the current federal COVID-19 Emergency Use Authorization Fact Sheet for Recipients and Caregivers and ask that the COVID-19 vaccine be given to me or to the person named for whom I am authorized to make this request. I consent to the inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named above. I acknowledge that I understand that NCCHS is required to report to the Vaccine Adverse Event Reporting Systems (VAERS) any adverse events. I also acknowledge that I have received or been offered a copy of the Nemaha County Community Health Services' Notice of Privacy Practices with the effective date of September 25, 2013.

Recipient/Parent/Guardian Signature _____ Date_____

HEALTH SCREENING

1. Is the patient currently experiencing a high fever or other signs of illness?	Yes or No
2. Has the patient had a severe allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)	
• A component of a COVID-19 vaccine?	Yes or No
• A previous dose of COVID-19 vaccine?	Yes or No
• Any other vaccine or injectable medication?	Yes or No
3. Is the patient immunocompromised or is the patient on a medicine that affects their immune system?	Yes or No
4. Has the patient received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	Yes or No
5. Has the patient ever received a dose of COVID-19 vaccine? If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Janssen (J&J) ☐ Novavax ☐ Another Product_____	Yes or No
6. How many doses of COVID-19 vaccine has the patient received? _____	

7. Check all that apply to the patient:

☐ Have a history of myocarditis or pericarditis	☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)	☐ Have a history of Guillain-Barre Syndrome (GBS)
☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)	☐ Vaccinated with monkeypox vaccine in the last 4 weeks

HEALTH INSURANCE INFORMATION

Name of the Policy Holder (exactly as it appears on the insurance card) :_____

☐ Medicare: ID #_____

☐ Medicaid/Kancare: ID #_____ Aetna Sunflower United Healthcare

☐ Private Insurance: ID #_____ Group #_____
Insurance Co: _____ Insurance Co Address: _____
Relationship to insured: Self Spouse Child Other:_____

FOR CLINICAL USE ONLY

(Circle the appropriate vaccine, dose, extremity, site, route, and enter the manufacturer, lot #, and expiration date)

Vaccine	Dose	Ext.	Site	Route	Fact Sheet Date	Mfr./Lot #	Exp. Date
Private **Moderna 23-24** **6m-11yr**	**1 2**	**RT** **LT**	Deltoid Vastus Lat	IM 0.25mL	9/11/23		
Private **Moderna 23-24** **12yr and up**	**1**	**RT** **LT**	Deltoid Vastus Lat	IM 0.5mL	9/11/23		
Private **Pfizer 23-24** **12yr and up**	**1**	**RT** **LT**	Deltoid Vastus Lat	IM 0.3mL	9/11/23		
Public **Moderna 23-24** **6m-11yr**	**1 2**	**RT** **LT**	Deltoid Vastus Lat	IM 0.25mL	9/11/23		
Public **Moderna 23-24** **12yr and up**	**1**	**RT** **LT**	Deltoid Vastus Lat	IM 0.5mL	9/11/23		

Signature and Title of Vaccine Administrator **Date**