East Shore District Health Department
COVID-19 Vaccination Form

Information will be entered into CT WIZ
Connecticut Immunization System

Clinic Location:_____
First Name: _____ Email:_____
Middle Name: _____ Phone number: _____
Last Name: _____ Date of Birth: ____/____/_____
mm dd yyyy

Sex: Male Female Transgender Unknown

***Dose you are here for? (Choose 1):** 1st, 2nd, 3rd, Booster ***Brand (Choose 1):** Moderna

Insurance Information: (Need copies of ALL insurance cards.)
Insurance Company:_____ ID #: _____

Subscriber: _____ DOB:_____

Address:
Street:_____ County: _____
Street 2:_____ State:_____
City:_____ Zip Code: _____

Race (select all that apply)
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other Race
- ☐ Unknown

Ethnicity (select all that apply)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Patient Authorization for Vaccine Administration:

I have read or had explained to me the 10/19/23 Vaccine Information Fact Sheet for the COVID-19 vaccine and understand the risks and benefits. Furthermore, I have also had an opportunity to ask about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunization(s) by the person named below for whom I am the legal guardian ("Ward"). My medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to me or my Ward. I, for myself and on behalf of my Ward and each of our respective heirs, executors, personal representatives and assigns, hereby release the provisioning mass vaccination center, and it's affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt of my Ward of this or these immunization(s). Neither the provisioning mass vaccination center nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. The provisioning vaccine center will use and disclose your personal and health information or the personal and health information of your Ward, to treat you or your Ward, to receive payment of the care we provide, and for other healthcare operations. Healthcare operations include those activities we perform to improve the quality of care.

Signature: _____ Date:_____

Prevaccination Checklist for COVID-19 Vaccination

Name

For vaccine recipients (both children and adults):

The following questions will help us determine if there is any reason COVID-19 vaccine cannot be given today. **If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given.** It just means additional questions may be asked. If a question is not clear, please ask the healthcare provider to explain it.

	Yes	No	Don't know
1. How old is the person to be vaccinated?			
2. Is the person to be vaccinated sick today?	☐	☐	☐
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product was administered? ☐ Pfizer-BioNTech ☐ Janssen *(Johnson & Johnson)* ☐ Another Product ☐ Moderna ☐ Novavax			
• How many doses of COVID-19 vaccine were administered? _____			
• Did you bring the vaccination record card or other documentation?	☐	☐	
4. Does the person to be vaccinated have a health condition or is undergoing treatment that makes them moderately or severely immunocompromised? *This would include, but not be limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.*	☐	☐	☐
5. Has the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. Has the person to be vaccinated ever had an 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	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. Has the person to be vaccinated ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? *(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.)*	☐	☐	☐

8. Check all that apply to the person to be vaccinated:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months?
- ☐ Vaccinated with monkeypox vaccine in the last 4 weeks?

Form reviewed by **Date**

Below for Vaccinator Only!!

Vaccine Administered	Lot #	Exp. Day (mm/dd/yyyy)
○ Moderna		
○		

Dose Administered (1st or Booster)	Vaccinator

Site of Administration (IM)	Recipient Received VIS ?
○ Left	○ Yes
○ Right	○ No

Form Reviewed By: _____ Date: _____