East Shore District Health Department
COVID-19 2025-2026 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: ___/___/_____

Sex: Male Female Transgender Unknown mm dd yyyy

***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 Information for Recipients and Caregivers Fact Sheet 2025-2026 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:_____

The 2025/26 COVID-19 vaccine is FDA approved for everyone ages 65 and older, and patients 6 months to 64 with certain health conditions that put someone at high risk for severe outcomes from COVID-19 virus. Conditions include but are not limited to:

- Diabetes
- Past or current smoker
- Physically inactive
- Body mass index greater than 25
- Weakened immune system
- Heart disease, including high blood pressure
- Pregnancy
- Cancer
- Substance use disorders
- Mental health conditions
- Chronic lung disease including cystic fibrosis, asthma, COPD
- Chronic liver disease
- Kidney disease
- Dementia or a neurologic condition
- Blood disorders (including sickle cell disease)
- HIV or tuberculous infection
- Solid organ or blood stem cell transplant
- Any other conditions or situation that places you at high risk of severe illness from COVID-19 (consult medical provider if you are unsure)

- Please confirm you would like to receive the COVID-19 vaccine and ARE ELIGIBLE.

☐ YES ☐ NO

Screening Checklist for Contraindications to Vaccines for Adults

YOUR NAME _____

DATE OF BIRTH ____/____/____
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means we need to ask you more questions. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccine?	☐	☐	☐
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	☐	☐	☐
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☐	☐
11. Are you pregnant?	☐	☐	☐
12. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
13. Have you ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
14. Are you anxious about getting a shot today?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Below for Vaccinator Only!!

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

Dose Administered (1st or Booster)	Vaccinator

Site of Administration (IM)	Recipient Received Information for Recipients and Caregivers
o Left	o Yes
o Right	o No

Form Reviewed By: _____ **Date:** _____