DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
F-02792 (04/2021)

COVID-19 Community-Based Vaccination Clinic: Vaccine Administration Record and Screening

Information collected on this form will be used to document your authorization to be vaccinated. The information will be uploaded to the Wisconsin Immunization Registry (WIR). This information is then available to other health care providers that directly provide your health care to indicate your receipt of the COVID-19 vaccine. Information collected on this form is voluntary and confidential.

Please print clearly:

Patient Last Name	First Name	MI

Date of Birth (mm-dd-yyyy)	R	Mother's Maiden Name

Gender
☐ Male ☐ Female ☐ Transgender: Female to Male ☐ Transgender: Male to Female
☐ Transgender: Unspecified or Gender Non-Specific ☐ Prefer not to answer ☐ Other: _____

Street Address	City	County	Zip Code

Phone Number	Email	OK to Email?
( )		☐ Yes ☐ No

Ethnicity	Race			
☐ Hispanic	☐ African American or Black	☐ Asian	☐ Other:	
☐ Non-Hispanic	☐ American Indian or Alaskan Native	☐ White	_____	
☐ Prefer not to answer	☐ Native Hawaiian or other Pacific Islander	☐ Prefer not to answer	☐ Multi-race	

The following questions will help us to determine if there is any reason we should not give you the COVID-19 vaccine today. If you answer "yes" to any questions, it does not necessarily mean you should not be vaccinated. It just means that additional questions must be asked for your safety. If a question is not clear, please ask a staff member on site to explain it.	YES	NO
1. Are you sick today? Have you had any of the following symptoms: nasal congestion, headache, fever, cough, shortness of breath, nausea or vomiting in the last 24 hours?		
2. Are you currently in your isolation or quarantine period due to COVID-19?		
3. Have you ever received a dose of COVID-19 vaccine?		
4. Have you ever had a severe allergic reaction (anaphylactic) to any food, medication, vaccine, or previous COVID-19 vaccine? List:_____		
5. Have you received antibody therapy or convalescent plasma for COVID-19 treatment in the past 90 days?		
6. Have you received any vaccines in the past 14 days?		
7. Are you pregnant or breastfeeding?		

Acknowledgement and Consent
I am (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. I have received the U.S. Food and Drug Administration's (FDA) emergency use authorization (EUA) "Fact Sheet for Recipients and Caregivers." I have had a chance to read it and ask questions that were answered to my satisfaction. **I understand the benefits and risks of receiving a vaccine approved under an Emergency Use Authorization from the FDA.** I consent to receive the vaccine at a public location. I understand that I will be made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors. **I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or to the person above for whom I am authorized to make this request.** I give permission to share my or my child's immunization records with the Wisconsin Immunization Registry. I release and hold harmless all those involved in the administration of my vaccine from any and all liabilities or claims, whether known or unknown, arising out of, in connection with, or in any way related to the administration of my vaccine.

SIGNATURE – Vaccine Recipient; if under 18, must be a parent or guardian signature	Relationship	Date Signed

FOR INTERNAL USE ONLY

DATE & TIME	DOSE	VACCINE	LOT# EXP DATE	SITE	SIGNATURE & CREDENTIAL OF VACCINATOR
	☐ 1st Dose ☐ 2nd Dose	Moderna COVID-19 0.5 mL IM		☐ RD ☐ LD	
	☐ 1st Dose ☐ 2nd Dose	Pfizer-BioNTech COVID-19 0.3 mL IM		☐ RD ☐ LD	
	☐ 1st Dose	Janssen COVID-19 0.5 mL IM; single dose vaccine		☐ RD ☐ LD	

You are due for your second dose of the_____(mfg) COVID-19 vaccine.
Next Appt. Date: _____ **Time**:_____ **am/pm**