**COVID-19 Vaccine Screening and Agreement**

***for persons receiving Moderna OR Pfizer Vaccine***

Information collected on this form will be used to document that you have received vaccine(s). Information about your vaccine(s) may be shared through the Minnesota Immunization Information Connection (MIIC) with other health care providers, schools, health departments, and others authorized under law to receive it. If you have any questions, please ask your doctor or other health care provider. If you have questions about MIIC, refer to [MIIC and the Public (www.health.state.mn.us/people/immunize/miic/public.html)](https://www.health.state.mn.us/people/immunize/miic/public.html) or call 1-800-657-3970.

**Contact information – person being vaccinated**

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (street or P.O. Box):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ZIP code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race (circle one):** American Indian/Alaska Native --- Asian --- Native Hawaiian/Pacific Islander---

---Black/African-American --- White --- Other --- Unknown/undetermined

**Ethnicity (circle one):** Not Hispanic or Latino --- Hispanic or Latino

Do you have health insurance? Y or N

**Agreement**

By signing below, I understand, recognize, approve, and agree that:

* I have received and read or had explained to me the Emergency Use Authorization Fact Sheet for the following COVID-19 vaccine: Moderna Pfizer
* I have had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described.
* I agree to receive the COVID-19 vaccine for myself or for the person named above.

**Signature of patient or parent/guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date: / /**

**Health history:** Based on your answers below, we may need more information from you.

|  |  |  |  |
| --- | --- | --- | --- |
| **Yes** | **No** | **Unknown** | **Question** |
| Yes | No |  | Are you the correct age to receive the COVID-19 vaccine?   * Pfizer vaccine: You must be at least 5 years or older. * Moderna vaccine: You must be 18 years or older |
| Yes | No | Unknown | Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine? |
| Yes | No | Unknown | Immediate allergic reaction (within 4 hours) of any severity to a previous COVID-19 vaccine dose or known (diagnosed) allergy to a component of the vaccine or any of its ingredients (including polyethylene glycol [PEG] or polysorbate)? |
| Yes | No | Unknown | Immediate allergic reaction to any other vaccine or injectable therapy (e.g., shots in the muscle (intramuscular), in the vein (intravenous), or into the fatty tissue (subcutaneous)? Does not include allergy shots. |
| Yes | No | Unknown | Are you feeling sick today |
| Yes | No | Unknown | Received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days? |
| Yes | No | Unknown | Exposed to another person with known COVID-19 disease? |
| Yes | No | Not applicable | Have you ever received a dose of COVID-19 vaccine?  If yes, list vaccine product and date received: |
| Yes | No | Not applicable | Did you have a delayed allergic reaction at the injection site (e.g., skin rash, itching) after a first dose of mRNA COVID-19 vaccine? |
| Yes | No | Not applicable | Are you on any immunosuppressants that might decrease your immune response to the vaccine? ( e.g rituximab, mycophenolate, methotrexate, baracitinib, abatacept, prednisone >20mg/daily) |

**DO NOT WRITE BELOW THIS LINE**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **COVID-19 Vaccine Presentation1** | **EUA Fact Sheet given?** | **Route2** | **Manufacturer3** | **Lot Number** | **Admin Site4** | **Person Admin5** |
| Pfizer 12+ (gray cap)  0.3 ml Dose |  | IM | PFR |  |  |  |
| Pfizer 5-11 (orange cap)  diluted  0.2ml Dose |  |  |  |  |  |  |
| Moderna Booster  0.25ml Dose |  | IM | MOD |  |  |  |
| Moderna Primary  0.5ml Dose |  | IM | MOD |  |  |  |

Signature and title of person administering vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date administered: \_\_\_/\_\_\_/\_\_\_\_\_\_\_\_