LakeCounty
Health Department and
Community Health Center

Lake County Health Department and Community Health Center
COVID-19 Vaccination Documentation & Intake Form

Patient Information

Last Name:		First Name:		Middle Initial:
Date of Birth:	Age:	Sex: ☐ Male ☐ Female ☐ Transgender ☐ Declined to Answer	Email:	
Home Phone:	Cell Phone:	Lake County Health Department Clinic (FQHC) or Behavioral Health Patient? Yes No		
Home Address:	Apt #:	City:	State:	Zip:
Race (Circle One): American Indian or Alaska Native Asian Black or African-American Native Hawaiian or Pacific Islander White Other Race Unknown				
Ethnicity (Circle One): Hispanic or Latino Not Hispanic or Latino Unknown				

Patient Handouts (check all forms received)

☐ Consent form
☐ Notice of Privacy Practices
☐ Emergency Use Authorization Fact Sheet (Pfizer or Moderna)
☐ What to Expect after Getting a COVID-19 Vaccine
☐ Steps to Take After Your COVID-19 Vaccination
☐ V-Safe Flyer

Acknowledgement: I have received the documents listed above and understand that I can ask questions prior to vaccination.

_____ _____ _____
Signature of Client (over 18 years), or Parent, Guardian, or Authorized Representative Printed Name Date

Screening Questionnaire for COVID Immunization

		Yes	No
1)	Are you sick today?	☐	☐
2)	Have you ever received a dose of COVID-19 Vaccine?	☐	☐
3)	Have you ever had a severe allergic reaction (e.g. Anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen or for which you had to go to the hospital?	☐	☐
	a. Was the severe allergic reaction after receiving a COVID-19 Vaccine?	☐	☐
	b. Was the severe allergic reaction after receiving another vaccine or another injective medication?	☐	☐
4)	Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐
5)	Have you tested positive for COVID-19 in the past 10 days or been exposed to COVID-19 in the past 14 days?	☐	☐
6)	Have you received monoclonal antibodies (e.g., Regeneron) or convalescent plasma as part of COVID-19 treatment in the past 90 days?	☐	☐
7)	Have you had any vaccine in the past 14 days or plan to be vaccinated with another vaccine in the next 14 days?	☐	☐
8)	Are you pregnant or breastfeeding OR have a weakened immune system (HIV, cancer, immune system problems, or on medications that weaken immune system?	☐	☐
9)	Do you have a severe allergy to any ingredient included the vaccine (complete list shown below)?	☐	☐

Ingredients Included in Pfizer BioNTech COVID-19 Vaccine
mRNA, lipids: ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-Distearoyl-sn-glycero-3- phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose.
Ingredients Included in Moderna COVID-19 Vaccine
mRNA; lipids, 1 monomethoxypolyethyleneglycol-2,3-dimyristylglycerol with polyethylene glycol of average molecular weight 2000 (PEG2000-DMG), 1,2-distearoyl-sn-glycero-3-phosphocholine, cholesterol, SM-102 (proprietary to Moderna); and tris buffer containing sucrose and sodium acetate

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Screener Documentation

LakeCounty
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Screener's Comments (use additional space on back of form if necessary): _____

_____

_____

_____

☐ Consent to Treatment and Payment is signed by the patient, witnessed by clinic staff, and attached to this intake form.
☐ Counselling provided. This includes provision of pre-vaccination and risk factor information, and answering patient questions.

_____ _____ _____
Screener Signature **Screener Printed Name and Title** **Date**

Patient Last Name _____ First Name_____ Date of Birth _____

COVID-19 Vaccine

Route: ☐ Intramuscular
Site: ☐ Right Deltoid ☐ Left Deltoid ☐ Anterolateral Thigh

Dose: ☐ 0.3 ml Pfizer/BioNTech COVID-19 Vaccine
☐ 0.5 ml Moderna COVID-19 Vaccine

Lot #: _____ Exp. Date: _____ Record: ☐ Vaccination record card provided to Patient

Vaccinator's Comments (use additional space on back of form if necessary): _____

_____

_____

_____

_____ _____
Vaccinator Signature **Vaccinator Printed Name and Title** **Date**

Vaccination Record Data Entry

Date Entered into ICARE:_____ Date Uploaded into AllVax:_____

ICARE PID:_____