# COVID-19 VACCINATION

DeKalb County Health Department

*Registration initials: _____*

**2550 N. ANNIE GLIDDEN ROAD DEKALB, IL 60115 (815) 758-6673** **PROVIDER # 36-6006548** **NPI # 1548315344**

**CLIENT INFORMATION (PLEASE PRINT)**

LAST NAME _____ FIRST NAME _____ MI_____

DATE OF BIRTH _____/_____/_____ AGE _____ ☐ MALE ☐ FEMALE

PHONE # _____ / _____ / _____ ☐ Can receive SMS text messaging at this number

ADDRESS _____ CITY _____ STATE _____ ZIP _____

COUNTY _____EMAIL _____

**SCREENING**

Are you feeling sick today? ☐ Yes ☐ No Are you pregnant or breastfeeding? ☐ Yes ☐ No

Do you have a weakened immune system caused by a disease/disorder, or do you take an immunosuppressive drugs or therapies? ☐ Yes ☐ No

Have you received passive antibody therapy as treatment for COVID-19? ☐ Yes ☐ No

Have you received or are you planning to receive any other vaccine within 14 days of receiving the COVID-19 vaccine? ☐ Yes ☐ No

Have you ever received a dose of COVID-19 vaccine? ☐ Yes ☐ No

If yes, date of 1st dose: _____ (NOTE: 2nd dose of Moderna is at least 28 days after first dose; Pfizer is at least 21 days after first dose)

If yes, which vaccine product: ☐ Moderna ☐ Pfizer ☐ Other _____

Have you ever had a severe allergic reaction for which you were treated with epinephrine/EpiPen, or you had to go to the hospital? ☐ Yes ☐ No

If yes, to what? _____

Was the severe allergic reaction after receiving a COVID-19 vaccine? ☐ Yes ☐ No

Was the severe allergic reaction after receiving another vaccine or injectable medication? ☐ Yes ☐ No

**CLIENT'S ETHNICITY** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

**RACE** (check all that apply)

☐ African American ☐ Asian ☐ Caucasian

☐ American Indian ☐ Alaskan Native ☐ Other _____

**VACCINE CLIENT:** I have been given available vaccine information about the vaccine that will be administered. I have read or have had explained to me the information about the vaccine. I have had an opportunity to ask questions that were answered to my satisfaction. I believe I understand the benefits and the risks of the vaccine and ask that the vaccine checked below be given to me or to the person above for whom I am authorized to make this request. In the event a blood or body fluid exposure occurs, I understand the DeKalb County Health Department (DCHD) staff may need to obtain a blood sample from the person mentioned above.

**CONSENT**

I consent to my name, address, phone number, appointments, and immunization record to be maintained in, I-CARE, Electronic Medical Records, and other State and Federal record systems. I also authorize release of this record to my physician for compliance purposes. I also hereby acknowledge that a copy of the Notice of Privacy Practices from DCHD dated April 14, 2003 was made available. I understand that the COVID vaccine is a 2-step vaccine and agree to return on the prescribed date for the second injection. My signature below also indicates that all information provided on this form is true and accurate.

Signature of person authorized to make the request:

_____ _____ _____/_____/_____

**PRINT NAME** **SIGNATURE** **DATE**

**OFFICE USE ONLY**

| VACCINE | SITE | ✓ | | | |
|---|---|---|---|---|---|
| COVID-19 Moderna | LD / RD | | | Lot, expiration date, Manufacturer | Sticker Here |
| COVID-19 Pfizer-BioNTech | LD / RD | | | | |
| COVID-19 Janssen (J & J) | LD / RD | | | | |

**SIGNATURE OF RN** _____ **DATE** _____/_____/_____

**I-CARE Entry Date** _____ **Initials**_____