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

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 ☐ Janssen (J&J) ☐ 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

Are you a female between ages 18 and 49 years old? ☐ Yes ☐ No

Are you a male between ages 12 and 29 years old? ☐ Yes ☐ No

Do you have a history or myocarditis or percarditis? ☐ Yes ☐ No

Have you received monoclonal antibodies or convalescent serum as treatment for COVID-19? ☐ Yes ☐ No

Have been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection? ☐ 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

Do you have a bleeding disorder? ☐ Yes ☐ No

Do you take a blood thinner? ☐ Yes ☐ No

Do you have a history of heparin-induced thrombocytopenia (HIT)? ☐ Yes ☐ No

Are you pregnant or breastfeeding? ☐ Yes ☐ No

ETHNICITY/ RACE

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

RACE (check all that apply)

☐ African American ☐ Asian ☐ Caucasian

☐ American Indian ☐ Alaskan Native ☐ Other _____

INFORMATION

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

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

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