

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 last dose: _____ (NOTE: 1st Booster dose of Moderna/Pfizer is at least 5 months after second dose; Janssen (J&J) is at least 2 months 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 of myocarditis or pericarditis? 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 immunosuppressive drugs or therapies? 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 ____/____/____

VACCINE	SITE (CIRCLE)	1ST/2ND ✓	1st/2nd BOOSTER ✓	OFFICE USE ONLY	
				Sticker Here	
COVID-19 Moderna (0.5ml)	LD / RD				
COVID-19 (0.5ml) Moderna Bivalent Booster (age 18+)	LD / RD				
COVID-19 (0.3ml) Pfizer-BioNTech	LD / RD				
COVID-19 (0.3 ml) Pfizer-BioNTech Bivalent Booster (age 12+)	LD / RD				
COVID-19 (0.2 ml) Pfizer-BioNTech Pediatric (age 5-11)	LD / RD				

SIGNATURE OF RN _____ DATE ____/____/____

I-CARE Entry Date _____ Initials _____