DeKalb County Health Department
Prevent • Protect • Promote

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

Does your child have any of these symptoms today: fever, cough, vomiting, diarrhea, or seem irritable? ☐ Yes ☐ No

Has your child ever received a dose of COVID-19 vaccine? ☐ Yes ☐ No

If yes, date of last dose: _____

If yes, which vaccine product: ☐ Moderna ☐ Pfizer

Has your child ever had a severe allergic reaction for which they were treated with epinephrine/EpiPen, or 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

Does your child have a history of myocarditis or pericarditis? ☐ Yes ☐ No

Has your child been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection? ☐ Yes ☐ No

Does your child have a weakened immune system caused by a disease/disorder, or does your child take an immunosuppressive drugs or therapies? ☐ Yes ☐ No

Does your child have a bleeding disorder? ☐ Yes ☐ No

Does your child take a blood thinner? ☐ Yes ☐ No

Does your child have a history of heparin-induced thrombocytopenia (HIT)? ☐ 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 or 3 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 (CIRCLE)	1ST/2ND ✓	3rd ✓	Booster ✓	Sticker Here
COVID-19 Moderna Pediatric (0.25ml) (6mo-5 years)	LD / RD LAT / RAT				
COVID-19 Moderna Bivalent Booster Pediatric (0.2ml) (6mo-5 years)	LD / RD LAT / RAT				
COVID-19 (0.2 ml) Pfizer-BioNTech Pediatric (age 6mo-4 years)	LD / RD LAT / RAT				
COVID-19 (0.2 ml) Pfizer-BioNTech Biavalent Booster Pediatric (age 6mo-4 years)	LD / RD LAT / RAT				
COVID-19 (0.2 ml) Pfizer-BioNTech Pediatric (age 5-11)	LD / RD LAT / RAT				
COVID-19 (0.2 ml) Pfizer-BioNTech Biavalent Booster Pediatric (age 5-11)	LD / RD LAT / RAT				

SIGNATURE OF RN _____ **DATE** _____ / _____ / _____ **WEIGHT:** _____ **lbs**

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