

COVID-19 VACCINE ADMINISTRATION RECORD (VAR)
About the person getting injection (Please Print)

Patient Name: _____ Patient Age: _____

I am a Linn County Department of Health Services employee.

SCREENING QUESTIONS FOR PERSON RECEIVING INJECTION		
The questions below will help us decide if the vaccine may be given today. If you need help with these questions, please ask the clinic staff to help you.	Check (☑) Yes or No	
	YES	NO
1. Are you feeling sick today?		
2. Have you ever received a dose of COVID-19 vaccine?		
<ul style="list-style-type: none"> • If yes, which vaccine product? <ul style="list-style-type: none"> <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Johnson & Johnson (Janssen) <input type="checkbox"/> Other: _____ 		
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?		
<ul style="list-style-type: none"> • Was the severe allergic reaction after receiving a COVID-19 vaccine? 		
<ul style="list-style-type: none"> • Was the severe allergic reaction after receiving another vaccine or another injectable medication? 		
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?		
5. Have you received another vaccine in the last 14 days?		
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
8. Are you pregnant or breastfeeding?		



Patient Name

Last: _____ First: _____ Middle: _____

Date of Birth: ____/____/____ Age: _____ Sex : Male Female
 M D Y

Mailing Address: _____ City: _____ Zip: _____

Phone number: (____) _____ - _____ Email: _____

Hispanic Ethnicity? Yes No Unknown Primary Language: _____
 Race: American Indian/ Alaska Native Hispanic/Latino Native Hawaiian/ Pacific Islander
 Black/ African American White Asian Other: _____

I have received, read and had questions answered about the EMERGENCY USE AUTHORIZATION (EUA) on the COVID-19 Vaccine to be given to me. I am aware that some people may experience physical responses to the injection; such as (but not limited to) injection site pain, light-headedness or fainting. I understand the benefits and risks and request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

I agree that I can review the Notice of Privacy Practices for Linn County Health Department located at <https://www.linncountyhealth.org/ha/page/compliance-privacy-office>.

Individual's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

THIS SECTION FOR CLINIC USE ONLY							
Dose #	EUA Given	Brand	Lot #	Exp. Date	Manuf.	Dose (ML)	Site/Rte
					Pfizer BioNTech	0.3	RD LD
					Moderna	0.5 / 0.25	RD LD
					Johnson&Johnson (Janssen)	0.5	RD LD
Date:		Vaccine Administrator Full Name/Credentials:					
Time:		Vaccine Administrator Signature:					