Immunization Information System Data Requirement Form

COVID-19 Vaccine Administration

This form can be used in the rare instances when you are unable to access your jurisdiction's IIS due to technical issues or lack of internet access. When possible, information should always be captured electronically to avoid the least number of possible mistakes when transcribing.

However, this form may be printed to capture information manually. Vaccination providers are required to report vaccination administration information within 72 hours of administration. This information should be entered as soon you are able to access your jurisdiction's IIS or VAMS.

Recipient Information

ID _____

First Name _____

Middle Name (optional) _____

Last Name _____

Date of Birth _____

Sex Male Female Unknown

Insurance Information (Optional) _____

Insurer _____

Primary insurance holder _____

Group/Individual ID number _____

Address

Street 1 _____

Street 2 _____

City _____

County _____

State _____

Zip Code _____

Race *(select all that apply)*

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Black/African American
- ☐ White
- ☐ Other Race
- ☐ Unknown
- ☐ Unable to report

Ethnicity *(select all that apply)*

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Unable to report

Vaccine Information

Type	Product	Date Administered	Manufacturer	Lot Number	Expiration Date *mmddyyyy*	# Wasted

Administration Site	Administration Route
LA (Left arm)	
RA (Left arm)	C28161 (Intramuscular)
LE (lower extremity) Left Right	

Dose Number		**Missed Appointment**	Y/N	**Comorbidity**	Y/N
Refused Vaccination	Y/N	**If Yes, Reason**			
Vaccinator		**Received EUA Fact Sheet for Recipients**	Y/N		

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name _____

Age _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product _____			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of a COVID-19 vaccine including either of the following:			
○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
• A previous dose of COVID-19 vaccine.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists

AccessHealth Covid-19 Vaccine Consent

Vaccine: Pfizer-BioNTech COVID-19 Vaccine

Patient Name: _____

Date of Birth: _____ / _____ / _____

Contact Telephone: (_____) _____ - _____

Authorizing Name if Not the Patient: _____

I certify that I am: (a) the patient and at least 16 years of age; (b) the legal guardian of the patient and I confirm that the patient is at least 16 years of age; (c) authorized to consent for vaccination for the patient named above or, (d) the patient and at least 18 years of age.

I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 16 years of age and older.

I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

I acknowledge that I have been advised to remain at the vaccination location for 15 minutes (up to 30 minutes on request) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.

I have received the following documents via email or hard copies: "Fact Sheet for Recipients and Caregivers", CDC "V-Safe After Vaccination Health Checker" and the "What to Expect after Getting a Covid-19 Vaccine" documents.

I hereby give my consent to CHS Inc. d.b.a. AccessHealth and its employees or agents to administer the COVID-19 vaccine.

_____

Signature of Patient or Authorized Representative and Date:

_____

If not the Patient, Print Name of Representative and Relationship to Person Receiving Vaccine: