Reviewer Initials: ____ WIR Entry Date:_____ Updated December, 2020

Samaritan CAMPUS
Samaritan Health Center • The Fields

Samaritan Campus

COVID-19 Vaccine Administration Record and Screening

Information collected on this form will be used to document authorization for receipt of vaccines. The information will be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and confidential. **Please Print.**

Client Name: Last: | | | | | | | | | | | | | | | **First:** | | | | | | | | | | | | **MI:** |

Age:_____ **Date of Birth:** month: _____ day:_____ year: _____ **Gender:** ☐ Male ☐ Female ☐ Other

SSN: _____

Address:_____ **City:**_____ **Zip:**_____ **Telephone:** _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Race:** ☐ Black/African American ☐ American Indian ☐ Asian ☐ White ☐ Other race

Questions for person receiving vaccine Are you receiving ☐ Dose 1 ☐ Dose 2? ☐ Booster **Which vaccine are you receiving?** ☐ Pfizer ☐ Moderna ☐ J&J	**Yes**	**No**
1. Are you sick today? (fever, cough, shortness of breath, nausea/vomiting in the last 24 hours)	☐	☐
2. Are you currently in your isolation or quarantine period due to COVID-19?	☐	☐
3. Have you ever had an observed anaphylactic reaction? If so, was it to a component of the COVID-19 vaccine, another vaccine, or an injectable (e.g., intramuscular, intravenous, or subcutaneous) therapy? List:	☐	☐
4. Have you received antibody therapy or convalescent plasma for COVID treatment in the past 90 days?	☐	☐
5. Have you received another vaccine in the past 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. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐
9. Are you pregnant or breastfeeding?	☐	☐

I have been given a copy and have read, or have had explained to me, information about the diseases and the vaccine to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of receiving a vaccine approved under an Emergency Use Authorization from the FDA. I consent to receive the vaccine in a public location. I have been made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors. **I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me, or the person to whom I am an authorized representative.**

Signature _____ **Date:** _____

Relationship to recipient _____

FOR VACCINATOR

Vaccine	IM Site	
COVID-19	☐ RD ☐ LD	**Trade Name:** _____ **Exp. Date:** _____ **Man. Lot Num.:** _____

Signature & Title - Vaccine Administrator: _____ **Date:** _____