Vaccination Date: ______________

COVID-19 Vaccination Registration

Name:____ Date of birth:________________ Age:________
First Middle Last

Address:_______________________________________ City:______________________ State:_____ Zip:__________

Cell Phone:_________________ Home Phone:________________ Email address:__________________________

Preferred method of contact*: ☐ Voicemail ☐ Email ☐ Text Message

You will be contacted via the preferred method selected for appointment reminders and other important information

Gender: ☐ Male ☐ Female ☐ Other ___________________

Race: (Check all that apply) ☐ White ☐ Black or African-american ☐ American Indian or Alaska Native
☐ Asian ☐ Native Hawaiian or other Pacific Islander

Ethnicity: ☐ Latina/o or Hispanic ☐ Non-Latina/o or non-hispanic

Are you a person with a disability? ☐ Yes ☐ No

CONSENT FOR SERVICES

I consent to receiving the COVID-19 vaccine provided by the Louisiana Department of Health Office of Public Health (LDH-OPH). I understand that my personal health information is confidential and will only be used or shared as permitted by law.

*Answering "yes" to any question does **not** prevent you from being vaccinated. It means additional questions will be asked*

1. Is the person to be vaccinated sick today? ☐ No ☐ Yes

2. Has the person to be vaccinated ever received a COVID-19 vaccine? ☐ No ☐ Yes

☐ Pfizer BioNTech ☐ Moderna ☐ Janssen (J&J) ☐ Another product Date: _________

- Did the person bring their vaccination record or other documentation? ☐ No ☐ Yes

3. Has the person to be vaccinated had an allergic reaction any of the following:

- 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 ☐ No ☐ Yes
  - Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids ☐ No ☐ Yes
- A previous dose of COVID-19 vaccine ☐ No ☐ Yes

4. Has the person ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? ☐ No ☐ Yes

(This includes 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 caused hives, swelling, or respiratory distress, including wheezing.)

Check all that apply to the person to be vaccinated today:

☐ Has had a severe allergic reaction (e.g., anaphylaxis) to something other than a vaccine or injectable medication, such as food, pet, venom, environmental or oral medication allergies.

☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum.

☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection

☐ Has a weakened immune system caused by something such as HIV infection or cancer

☐ Takes immunosuppressive drugs or therapies

☐ Is a female between ages 18 and 49 years old ☐ Currently pregnant or breastfeeding

☐ Has a bleeding disorder ☐ Taking a blood thinner

☐ Has a history of heparin-induced thrombocytopenia (HIT) ☐ Has received dermal fillers

I have read, or have had explained to me, the Fact Sheet for Recipients and Caregivers prepared in connection with the Emergency Use Authorization for the COVID-19 vaccine I will be receiving. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the COVID-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

I HAVE BEEN ADVISED TO WAIT FOR THE APPROPRIATE OBSERVATION TIME AFTER RECEIVING MY VACCINE (15 or 30 MINUTES).

Print Client/Parent/Guardian name: ____

Client/Parent/Guardian Signature:_______________________________________ Date:______________

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ **FOR STAFF USE ONLY** ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

Name/Title of vaccinator:___________________________________ Signature___________________________

Office/Company address of vaccinator:________________________________ EUA given________ 2nd vaccine due date:__________

Manufacturer	Lot #	Expiration Date	Route	Dose	Injection site	EUA Date
Pfizer-BioNTech			Intramuscular (IM)	0.3 mL		5/10/21
Moderna			Intramuscular (IM)	0.5 mL		3/26/21
Janssen (J&J)			Intramuscular (IM)	0.5 mL		4/23/21

Entered into LINKS (initial and date)______________________________ Notes/Comments:______________________________