John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Public Health

State of Louisiana COVID-19 Vaccination Third Dose Medical Risk Factor Self-Attestation Form

The State of Louisiana along with the Centers for Disease Control and Prevention (CDC) now recommends that people whose immune systems are compromised moderately to severely and are fully vaccinated with an mRNA (Pfizer or Moderna) COVID-19 vaccine should receive an additional dose of that same mRNA COVID-19 vaccine. Patients may self-attest to their condition by completing and signing this form.

Please check next to the high-risk medical condition that you have and sign at the bottom of the form. The vaccination site will keep a copy of this form, and it may be audited by the State. Please bring this form (or a copy) to your vaccination appointment. No other documentation from your doctor is needed.

___ Receiving active cancer treatment for tumors or cancers of the blood

___ Received an organ transplant and are currently taking medicine to suppress the immune system

___ Received a stem cell transplant within the last 2 years or are currently taking medicine to suppress the immune system

___ Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)

___ Advanced or untreated HIV infection

___ Active treatment with high-dose corticosteroids (**≥20 mg prednisone or equivalent per day)** or other drugs that may suppress your immune response

___ Other conditions which cause moderate or severe immunosuppression similar to the above conditions

People should talk to their healthcare provider about their medical condition, and whether getting an additional dose is appropriate for them.

Signed: _____ Date: _____

- Please sign and bring this form to your vaccination appointment

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Phone: (225) 342-8093 ▪ Fax: (225) 342-4848 ▪ www.ldh.la.gov

LOUISIANA DEPARTMENT OF HEALTH
Public Health

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: _____