## Grant County Health Department

## COVID-19 VACCINATION Screening and Consent Form

Recipient's Last Name: _____ First Name: _____ Birthdate: _____

Address: _____ City: _____ Zip: _____

Phone: _____ ☐ Male ☐ Female

Mother's Maiden Name (First and Last): _____ Recipient's SSN: _____

Medicare #: _____ Insurance Company: _____

Medicare Advantage Ins. Co: _____ Insurance #: _____

Medicare Advantage Ins. #: _____ Medical Assistance #: _____

### SCREENING QUESTIONS

1. Have you received antibody therapy or convalescent plasma for COVID-19 treatment in the past 90 days? Yes ☐ No ☐
   i. If yes, date: _____
2. Do you have symptoms of COVID-19, cold, flu or other illness now? Yes ☐ No ☐
3. Have you received a COVID-19 vaccine ever? Yes ☐ No ☐
4. Have you ever had a severe allergic reaction to any vaccine or injectable medication? Yes ☐ No ☐
   i. If yes, list vaccine/medication and reaction: _____
5. For Women Only: Are you pregnant, plan to become pregnant or breastfeeding: Yes ☐ No ☐

### CONSENT

Grant County Health Department participates in the Wisconsin Immunization Registry Program (WIR). Participation in WIR is required for administration of the COVID-19 vaccine. By receiving this vaccine, you agree to allow Grant County Health Department to input your vaccination record for COVID-19 into the WIR.

I have been given a copy of the FDA Emergency Use Authorization Fact Sheet for the COVID-19 vaccine. I have read the fact sheet and have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of this vaccine and ask that the vaccine be given to me or the person for whom I am authorized to make this request.

I acknowledge that I have received a copy of the Grant County Health Department Notice of Privacy Practices and have been given an opportunity to discuss my concerns and/or questions. I consent to have my protected health information used for treatment, payment and health care operations.

Recipient's Signature: _____ Date: _____

Relationship to Vaccine Recipient (if applicable): _____

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## COVID-19 VACCINATION CONSENT FORM

# FOR OFFICE USE ONLY

COVID-19 Vaccine Administered

☐ First Dose ☐ Second Dose ☐ 1st Booster ☐ 2nd Booster ☐ 3rd Booster

☐ Full Dose ☐ Half Dose

Lot #: _____ Expiration Date: _____ Manufacturer: _____

Site of IM Injection: ☐ Right Deltoid ☐ Left Deltoid ☐ Right Vastus Lateralis ☐ Left Vastus Lateralis

Signature of Vaccine Administrator: _____ Date: _____