Coos Health & Wellness
Together, Inspiring Healthier Communities

Promotes and provides innovative quality health services, prevention, and education for our communities

281 LaClair Street, Coos Bay, OR 97420
p. 541-266-6700 • f. 541-888-8726

COVID-19 Vaccine Administration Record

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____

Phone: _____ Date of Birth: _____ Gender: Male Female

Race: American Indian/Alaska Native African American Asian White

Native Hawaiian Other Pacific Islander Decline

Ethnicity: Not Hispanic or Latino Hispanic or Latino

Primary Language: _____ Healthcare Provider: _____

Patient Screening Questions:

Do you have a fever or feel sick?	Yes	No
Have you received a COVID-19 vaccine? If Yes, which one? Pfizer Moderna J&J	Yes	No
Have you ever had a severe reaction to something? For example, a reaction for which you were treated with epinephrine/EpiPen, or went to a hospital?	Yes	No
Did you have an allergic reaction to the COVID-19 vaccine?	Yes	No
Did you have an allergic reaction after any type of vaccine or injectable medication?	Yes	No
Have you received passive antibody therapy as COVID-19 treatment?	Yes	No
Do you have a bleeding disorder or taking a blood thinner?	Yes	No
Have you fainted after injections?	Yes	No
Are you pregnant or breastfeeding?	Yes	No

Immunocompromised Questions:

Active treatment for solid tumor or hematologic malignancies?	Yes	No
Receipt of solid-organ transplant and taking immunosuppressive therapy?	Yes	No
Receipt of CAR*-T-Cell or hematopoietic stem cell transplant in the last 2 years?	Yes	No
Moderate or severe primary immunodeficiency (e.g.DiGeorge, Wiskott-Aldrich)?	Yes	No
Advanced or untreated HIV infection?	Yes	No
Active treatment with high-dose corticosteroids (20mg prednisone or equivalent per day)?	Yes	No
Alkylating agents, antimetabolics, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, TNF blockers, and other biologic agents that are immunosuppressive or immunomodulatory.	Yes	No

Adult Consent:

I have read or have had explained to me the information provided in the Factsheet or Vaccine Information Statement about the COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the COVID-19 vaccine and ask that the vaccine be administered to me or to the person named above for whom I am authorized to make this request.

Signature: _____ Date: _____

Parent or Guardian Consent for Minor Vaccination:

I have reviewed the information on the risks and benefits of the Pfizer COVID-19 Vaccine and understand the risks and benefits. In providing my consent below, I agree that:

1. I have reviewed this consent form, and I understand that the "Fact Sheet for Recipients and Caregivers" includes more detailed information about the potential risks and benefits of the Pfizer COVID-19 Vaccine.
2. I have the legal authority to consent on behalf of the child/minor named above to vaccination with the Pfizer COVID-19 Vaccination.
3. I understand I may not be required to accompany the child/minor named above to their vaccination appointment and that, by giving my consent below, the child/minor will receive the Pfizer COVID-19 Vaccine whether or not I am present at the vaccination appointment.

I GIVE CONSENT for the child/minor named at the top of this form to get vaccinated with the two-dose Pfizer COVID-19 Vaccine and have reviewed and agree to the information included in this form. The scope of this consent includes administration of the vaccine, discussion with a provider if requested, care and treatments immediately after administration as needed (if this consent is not signed, dated and returned, the child/minor will not be vaccinated).

Relationship to child/minor: _____ Printed Name : _____

Signature: _____ Date: _____

Insurance Information:

Please provide medical insurance information for the vaccine recipient. If MEDICARE we need these numbers not supplemental managed care plans.

Insurance Name: _____

Member ID: _____ Group #: _____

Social Security Number: _____ Cardholder Name: _____

Official Use Only:

Dose #	Vaccine	Brand/ Manuf	Lot #	Exp	Dose (ML)	Site	EUA Pub Date	Elig.	EUA VIS
	COVID	Moderna			0.5		12/2020	S	
	COVID	Pfizer			0.3		12/2020	S	
	COVID	J&J			0.5		3/2021	S	

Vaccine Administrator Signature: _____ Title: _____ Date: _____