Door County Public Health
COVID-19 VACCINATION Screening and Consent Form

I have been given a copy and read or have had explained to me the information in the Emergency Use Authorization (EUA) of the applicable COVID-19 Vaccine to prevent Coronavirus disease 2019. I understand the benefits and risks of the COVID-19 vaccine and request that the immunization be given to me or the person named below for whom I am authorized to make this request.

I agree to remain at the vaccination site for 15 minutes following the immunization.

I also understand that the information collected on this form will be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure continuation of health care services.

Information of PERSON TO RECEIVE vaccine (Please Print Clearly)

Name	Sex	Date of Birth	Age

Mailing Address	City	State	Zip Code

Phone Number

The following questions will help us determine if there is any reason we should not give you injectable COVID-19 vaccine today. If you answer yes, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked.

	Yes	No
1. Are you currently in an isolation or quarantine period due to COVID-19?	☐	☐
2. Are you sick today?	☐	☐
3. Have you received antibody therapy or convalescent plasma for COVID-19 treatment in the past 90 days? a. If yes, date: _____	☐	☐
4. Have you ever had a severe allergic reaction to any vaccine or injectable medication? a. If yes, list vaccine/medication and reaction: _____	☐	☐
5. What is your vaccine preference today? Pfizer Janssen Moderna		
6. **For Pfizer and Moderna Vaccine only**: What dose of COVID-19 vaccine is the vaccine recipient receiving? a. If you received DOSE 1, what vaccine did you receive? **CIRCLE:** Pfizer Moderna N/A b. If you received DOSE 1, what date did you receive the vaccine? **Date:** _____	**Dose 1** ☐	**Dose 2** ☐
7. **FOR ADDITIONAL (3RD) DOSES AND BOOSTER DOSES ONLY** Are you here for an additional (3rd dose) or a booster dose? Yes or No If yes, what vaccine did you previously receive? Pfizer Moderna What date did you receive your 2nd dose? _____		

SIGNATURE **X**	**Date Signed**

Office Use Only

Date Vaccine Administered	Vaccine	Route	Site		Manufacturer			Lot Number
	COVID-19	IM	LD	RD	Pfizer	Moderna	Janssen	

Signature and Title of Vaccine Administrator_____ **Date**_____