COVID-19 Vaccine Screening and Agreement

Information collected on this form will be used to document that you have received vaccine(s). Information about your vaccine(s) may be shared through the Minnesota Immunization Information Connection (MIIC) with other health care providers, schools, health departments, and others authorized under law to receive it. If you have any questions, please ask your doctor or other health care provider. If you have questions about MIIC, refer to [MIIC and the Public (www.health.state.mn.us/people/immunize/miic/public.html)](www.health.state.mn.us/people/immunize/miic/public.html) or call 1-800-657-3970.

Contact information – person being vaccinated

Patient's name (last, first, middle):

Date of birth: Age:

Primary phone number: Address, City, State, Zip:

Mother's name, if applicable (last, first, middle - if younger than 18 years):

Mother's maiden name, if applicable (if younger than 18 years):

Agreement

By signing below, I understand, recognize, approve, and agree that:

- I have received and read or had explained to me the Emergency Use Authorization Fact Sheet for the COVID-19 vaccine I will be receiving today.
- I have had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described.
- I agree to receive the COVID-19 vaccine for myself or for the person named above.

Signature of patient or parent/guardian: ____. Date: __________

Health history

If you answer yes to any of these questions, the person giving you the vaccine may need more information from you before you get the vaccine:

Yes	No	Unknown	Question
Yes	No		Are you the correct age to receive the COVID-19 vaccine? • Pfizer-BioNTech vaccine: You must be 5 years or older. • Moderna vaccine: You must be 18 years or older. • Johnson & Johnson (Janssen) vaccine: You must be 18 years or older.
Yes	No	Unknown	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine?
Yes	No	Unknown	Immediate allergic reaction (within 4 hours) of any severity to a previous COVID-19 vaccine dose or known (diagnosed) allergy to a component of the vaccine or any of its ingredients (including polyethylene glycol [PEG] or polysorbate)?
Yes	No	Unknown	Immediate allergic reaction to any other vaccine or injectable therapy (e.g., shots in the muscle (intramuscular), in the vein (intravenous), or into the fatty tissue (subcutaneous)? Does not include allergy shots.
Yes	No	Unknown	Are you feeling sick today?
Yes	No	Unknown	Received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days?
Yes	No	Unknown	Exposed to another person with known COVID-19 disease within the last 14 days?
Yes	No	Not applicable	Have you ever received a dose of COVID-19 vaccine? If yes, list vaccine product and date(s) received:
Yes	No	Not applicable	Did you have a delayed allergic reaction at the injection site (e.g., skin rash, itching) after prior doses of mRNA COVID-19 vaccine?

DO NOT WRITE BELOW THIS LINE

Vaccine information

COVID-19 Vaccine Presentation[1]	EUA Fact Sheet Date	Route[2]	Manufacturer[3]	Lot Number	Admin Site[4]	Person Admin[5]
COVID-19 (Pfizer)		IM	PFR			
COVID-19 (Moderna)		IM	MOD			
COVID-19 (Janssen)		IM	JSN			

1. **COVID-19 Vaccine Presentation** = lists specific product name (e.g., Pfizer-BioNTech, Moderna, Janssen, etc.)
2. **Route:** IM = Intramuscular
3. **Manufacturer:** MOD = Moderna, PFR = Pfizer, JSN = Janssen
4. **Site Vaccine Given:** LD = Left Deltoid, RD = Right Deltoid, LT = Left Thigh, RT = Right Thigh
5. **Signature or initials of person administering vaccine:** Can be used if more than one person is administering vaccines.

Signature and title of person administering vaccine: ____

Date administered: ___/___/________