COVID-19 Vaccine Administration Record	Mercer County Health Department 305 NW 7th Street, Aledo, IL 61231	Phone: (309) 582-3759 Fax: (309) 582-3793

Patient FULL LEGAL NAME - First: Last Name:	Sex (Circle one): Male Female	Date of birth:
Mailing Address:	**City:**	**Zip:**

Patient or Parent/Guardian Phone Number: **Parent/Guardian Name (please print):**

Race (Circle One): *American Indian or Alaska Native* *Black or African-American* *White* *Hispanic or Latino* *Asian* *Native Hawaiian or other Pacific Islander* *Other race*_____ *Unknown*

Ethnicity (Circle One): *Hispanic or Latino* *Not Hispanic or Latino* *Unknown*

The following questions will help us determine if there is any reason the patient should not get the COVID-19 vaccine today. If the answer is "Yes" to any question, it does not necessarily mean that the patient should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it. **(Please circle one)**

1. Has patient ever received a dose of COVID-19 vaccine?	***Yes or No***
If yes, circle which product: ***Pfizer for ages 12+*** ***Moderna*** ***Janssen*** ***Pediatric Pfizer for ages 5-11*** ***Other***	
If yes, circle which dose is patient requesting today: ***2nd Dose*** ***3rd Dose for Immunocompromised*** ***Booster Dose***	
2. What is the age of the patient today (day of vaccination) ?	
3. Has patient had a fever in the last 48 hours?	Yes or No
4. Is patient experiencing any of the following symptoms: Headache, loss of taste or smell, cough, shortness of breath, wheezing, fatigue, sore throat, runny nose, congestion, chills, muscle ache, rash, abdominal discomfort, diarrhea, vomiting.	Yes or No
5. Has patient ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction which required treatment with epinephrine or EpiPen, or for which the patient had to go to the hospital?	Yes or No
• **Was the severe reaction after receiving a COVID-19 vaccine?**	Yes or No
• **Was the severe allergic reaction after receiving another vaccine or injectable medication?**	Yes or No
6. Has patient received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	Yes or No
7. Has patient had a positive test for COVID-19, has a doctor ever diagnosed patient with COVID-19, or is patient currently awaiting results from a COVID-19 test?	Yes or No
8. Does the patient have a weakened immune system caused by something such as HIV infection or cancer or does patient take immunosuppressive drugs or therapies?	Yes or No
9. Is the patient at higher risk for severe COVID-19 due to their home or work setting, or underlying medical condition?	Yes or No
10. Does patient have a bleeding disorder or is he/she taking a blood thinner?	Yes or No
11. Is patient pregnant or breastfeeding?	Yes or No

If you are under the age of 18, your custodial parent or a legal guardian may consent on your behalf and sign this form; minors may not consent for vaccination unless they are emancipated by a court, pregnant, married, minor-parents, or a "minor seeking primary care" with verification of status in writing by a qualified adult under the IL Consent by Minors Act.

As the custodial parent or legal guardian, I authorize giving the Pfizer COVID-19 vaccine to the person named above. I understand that the Pfizer vaccine is the only one currently authorized for those under age 18. I know that side effects are normal, may or may not occur, and I will notify the patient's primary care provider of any adverse reactions. I further acknowledge receiving the "Vaccine Information Sheet" for the COVID-19 vaccine.

Signature of patient, if 18 years or older – or parent/legal guardian, if under age of 18 **Date**

FOR OFFICE USE ONLY	
Site of injection:	L or R
Manufacturer:	
Lot number:	

SIGNATURE OF VACCINE ADMINISTRATOR AND TITLE	
Date of Service:	