Recipient Registration and COVID-19 Vaccine Administration Form

Recipient Full Name: ____**Date of Birth** _____/_____/______

Recipient Email Address: ____ ☐ No email

Have you already registered in the COVID-19 Vaccine Portal? ☐ Yes ☐ No

Home Phone Number: ____________________________**Mobile Phone Number:** __________________________

Address: ____ **City:** __________________________________

Zip Code: _________________ **County:** _______________________________________**State:** _______________

Best way to contact you: ☐ SMS/Text Message ☐ Email ☐ Both ☐ None

Recipient Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown

Recipient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Recipient Gender: ☐ Male ☐ Female ☐ Other ☐ I do not want to specify

What is your Vaccine Group?

☐ Group 1	☐ Group 2	☐ Group 3	☐ Group 4	☐ Group 5
Health care workers & Long-Term Care staff and residents	*Anyone 65 years or older, regardless of health status or living situation*	*Frontline essential workers*	*Adults at high risk for exposure and increased risk of severe illness*	*Everyone else who wants a safe and effective COVID-19 vaccination*

☐ **I certify that I am**: (a) at least 18 years of age (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an 'applicable Provider'), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine.

Recipient Signature ____

OFFICE USE ONLY

☐ **Verbal Consent for COVID-19 Vaccine Obtained**

Site of Injection: ☐ Right Deltoid, IM ☐ Left Deltoid, IM ☐Other________________

Dose: ☐ First Dose ☐ Second Dose

Manufacturer sticker (optional)

Administration Date: _____/_____/__________

Administration Time: ____________________

COVID-19 Vaccine Manufacturer: ____________________________

Lot #: ____________________________ **Exp:** _____/_____/_______

Vaccine administered by (Clinician Name)_________________________ **Signature**__________________________

Vaccinating Clinic Name____

Form Version 9 – 3/3/2021 – North Carolina COVID-19 Vaccine Management System

Wilkes Health

COVID-19 Vaccination Screening Tool

1. Are you feeling sick today? Yes No

2. Are you 18 years old or older? (If no, please screen out and ask patient to take express lane, unless we have Pfizer then it is 16 years old.)

3. Have you had a previous **severe** allergic reaction to a vaccine, medication, food, pet, venom, or environmental agent. Yes No

4. Have you received any vaccine within the past 14 days? Yes_____ No_____ (If yes, screen out)
   a. **Inform patient that they cannot take any vaccine within 14 days after Covid-19 vaccination.**

5. Do you have a bleeding disorder or are you taking a blood thinner? Yes_____ No_____

6. Are you currently on isolation due to a positive COVID-19 test? Yes No

7. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? Yes No
   a. If yes, date: _______________

8. Are you pregnant or breastfeeding?
   a. Yes____
   b. No_____

9. Have you ever received a dose of COVID-19 vaccine? If so, which vaccine did you receive:
   a. Pfizer _____ b. Moderna_______ c. Johnson and Johnson___________