

McDonough County Health Department
505 E Jackson Macomb, IL 61455
309-837-9951



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

Patient Information:

M / F

Legal Last Name	Legal First Name	MI	Maiden Name	Date of Birth	Age	Gender
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Address	City	State	Zip
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Phone _____

Race: American Indian or Alaska Native Asian Black Refused
 Native Hawaiian/Pacific Islander White Other race Unknown

Ethnicity: Not Hispanic/Latino Hispanic/Latino

Is this the patient's first ___ second ___ or third ___ dose of the COVID-19 vaccination?

	YES	NO	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
If yes, which vaccine product? (Please circle) Moderna Pfizer Janssen (Johnson & Johnson) Date _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? Date _____			
5. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? Date _____			
6. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
7. Do you have a bleeding disorder or are you taking a blood thinner?			
8. Are you pregnant or breastfeeding?			

CONSENT FOR SERVICES: I have been provided and reviewed the COVID fact sheet. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine monitoring area for 15 minutes or as directed after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: contact doctor, call 911 I understand that a second dose of the vaccine will be required, and I agree to return for the 2nd dose. (Does not apply to the Janssen Vaccine) I request that the COVID vaccine be given to me.

DISCLOSURE OF RECORDS: I understand that it is required to report individuals vaccinated to the local Health Department for entry into state registry.

Signature of Parent/Guardian (for clients under 18 years of age) _____ **Date** _____

Signature _____ **Date** _____

VACCINE ADMINISTRATION INFORMATION

Lot#	Exp Date	Route	IM	Site	L / R	0.5 mL / 0.3ml
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Signature of Administering Immunizer Name & Title _____ **Date** _____