First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_

SS # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_ Hispanic or Non

 Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Id Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please answer the following questions**

|  |  |  |  |
| --- | --- | --- | --- |
| **Health History** | YES | NO | UNKNOWN |
| Have you ever received a COVID-19 vaccine? Moderna Pfizer J&J Novavax |  |  |  |
| Are you feeling sick today? |  |  |  |
| Have you had recent contact with someone who is sick? (in the past 7 days) |  |  |  |
| Do you have any allergies to food, medications, or vaccine components? (egg, PEG, polysorbate) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Do you have any immune system problems or a bleeding disorder?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(blood thinner) |  |  |  |
| Have you ever been told you have Guillain-Barre syndrome or MIS-A?(muscle weakness/paralysis) (multisystem inflammatory syndrome) |  |  |  |
| Have you ever experienced a problem with the COVID-19 shot in the past? |  |  |  |
| Pregnant or breastfeeding? |  |  |  |

**Please Read and Sign Below**

This record will be kept on file at the Macon Co. Health Dept. It will include when the vaccine was given, the name of the vaccine manufacturer, lot number, and injection site. I have read and been offered a copy of the **V**accine **I**nformation **S**tatement and have had the opportunity to ask questions and had them answered to my satisfaction. I understand the benefits of receiving the vaccine(s) and give my consent to receive the injection(s). I give consent for my insurance (if applicable) to be billed, **and if denied**, I understand that I am responsible for the payment in full. By signing below, I acknowledge that I have been offered a copy and/or read the HIPAA Privacy Act and agree to the statements above.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Staff Use Only:** Eligibility verified by Online or Phone (initials) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REV 03/23

**What You Need to Know** (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/expect/after.html)

* Side effects after getting a COVID-19 vaccine can vary from person to person.
* Some people experience a little discomfort and can continue to go about their day. Others have side effects that affect their ability to do daily activities.
* Side effects generally go away in a few days.
* Even if you don’t experience any side effects, your body is building protection against the virus that causes COVID-19.
* Common side effects on the arm where you got the shot:
	+ Pain, redness, swelling
* Common side effects throughout the rest of your body
	+ Tiredness, headache, muscle pain, fever, chills, nausea

**FOR CLINIC USE ONLY**

|  |  |  |
| --- | --- | --- |
| MANUFACTURER | BRAND | LOT NUMBER |
| DOSE NUMBER | \*EXP. DATE | \*DATE ADMINISTERED |
| \*EUA FACT SHEET DATE | \*EUA FACT SHEET GIVEN DATE | INJECTION SITE (DELTOID) L R |

|  |  |
| --- | --- |
| VACCINE DOSE | ADMINISTERED BY NAME & TITLE |

Macon County Health Department

503 N. Missouri Street

Macon, MO 63552

Ph. (660) 395-4711 Fax (660) 385-2014

Website: www.maconmohealth.org