COMPLETE AND BRING WITH YOU TO SCHEDULED VACCINATION APPOINTMENT

MINORS MUST BRING THIS COMPLETED FORM TO THEIR APPOINTMENT

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name ____________________

Age __________

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 question, it does not necessarily mean you 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.

PARENT/GUARDIAN TO COMPLETE (if minor)

	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 did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product ________			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of a COVID-19 vaccine including either of the following:			
○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
• A previous dose of COVID-19 vaccine.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Parent/Guardian Signature (if minor) ____________________ **Date** __________

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COVID-19 Vaccine Consent Form

Section 1: Information about Person to Receive Vaccine (please print)

Name: Date of Birth: Age: Sex (circle): M F

Race (circle): White / Black or African American / Asian / American Indian or Alaska Native / Other Pacific Islander	Ethnicity (circle): Non Hispanic / Hispanic Email:
Address:	Previous name(s):
City/State/Zip:	Phone:

Section 2: Screening for Vaccine Eligibility

Has this person been vaccinated with the COVID-19 vaccine? (circle) YES NO

Section 3: Consent

I understand I either have or will receive the Emergency Use Authorization (EUA) fact sheet prior to the administration of the vaccine and have the ability to revoke consent at any time.

Your signature indicates that you give consent to LLCHD and its staff for the person named at the top of this form to be vaccinated with this vaccine.

Client Signature OR Signature of Parent/Legal Guardian

X____ Relationship_____________________________

Date: Month________________________ Day______________ Year__________________

DO NOT WRITE BELOW THIS LINE: OFFICE USE ONLY

Section 4: Vaccine Administration Record

Injection Site (Deltoid) please circle: Left Right	Manufacturer: Pfizer Moderna AstraZeneca Johnson & Johnson Lot#:_________________________ Exp:_________________________

The vaccine administrator's signature below attests that the vaccine recipient's identity has been confirmed and that the vaccine recipient has been properly screened according to the CDC guidelines and recommendations.

Vaccine Administrator (signature): X____	Date:___________________________

MINORS ONLY MUST BRING THIS COMPLETED FORM TO THEIR APPOINTMENT

LINCOLN-LANCASTER COUNTY
HEALTH DEPARTMENT
3131 "O" Street Lincoln, NE 68510-1514
402-441-8000 TDD: 402-441-6284 fax: 402-441-6229

lincoln.ne.gov

AUTHORIZED CONSENT AND APPOINTMENT OF AGENT

I authorize the nurses and/or physician of Lincoln-Lancaster County Health Department to carry out any medical order, examine, immunize and/or test my child, ____, in my absence in accordance with the Health Department's schedules and policies, which I have authorized in writing.

Further, I hereby appoint _________________________ (adult 19 years or over), as my agent and representative for the purpose of authorizing and consenting to hospital care and/or medical care of the above-named child for any reaction to medicine, illness or injury while such person is in the care of the agency and when I am not immediately available to give such consent.

Allergies: ____

Last Tetanus Toxoid: ___________________________________

Family Physician: ______________________________________

Phone Number: ____

Dated this ____________ day of ________________ 20______

____
Parent or Guardian Signature

____
Address

____
Phone

____
Witness Signature

This statement can be revoked in writing at any time and expires in any event 60 days after it is signed.

Revised 1/2018