Children & Family Health Institute

COVID Vaccination Clinical Intake

Please write legibly & hand to nurse before you get your vaccine

Name: _____ Date of Birth: _____/_____/_____ Age: _____

Address: _____ Email: _____

Town: _____ Telephone Number: _____

~~Zip Code: _____ County: _____ Gender: Male _____ Female _____ Other _____~~

Do you have Health Insurance? Check one: Yes _____ or No_____

If YES, INSURANCE NAME: _____

INSURANCE ID #: _____

Any Medication Allergies?:	Reaction:	Severity (circle one):
_____	_____	mild/moderate/severe
_____	_____	mild/moderate/severe

Are you **immunocompromised**? Circle One: Yes No

Are you feeling sick today? Circle One: Yes No

If YES, please explain concerning symptoms: _____

Today I am here for Vaccine (Circle Vaccine): MODERNA PFIZER (≥12 y/o)

PEDIATRIC PFIZER (5 to 11 y/o)

Today I am here for Dose # (Circle Dose): Dose #1 Dose #2 Dose #3 Dose #4 Dose #5

Please fill out the doses previously administered:

Dose #1:	Dose #2:	Dose #3:	Dose #4:
Lot#:_____	Lot#:_____	Lot#:_____	Lot#:_____
Date:_____	Date:_____	Date:_____	Date:_____

Nurse to Complete Below This Line: _____

Date: _____/_____/_____ Time: _____:_____ INJECTION SITE (Circle One): LEFT DELTOID RIGHT DELTOID

PFIZER LOT #_____	MODERNA LOT #_____	BIVALENT:
___PEDIATRICS 5 yrs – 11 yrs is 0.2 mL	___ 0.5 mL	___0.5 mL **MODERNA** Lot#:_____
___ADULT 12 yrs + is 0.3 mL		___0.3 mL **PFIZER** Lot#:_____

____I have reviewed side effects with patient (and parent, guardian, or surrogate, as applicable)

____I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

____I offered the EUA to client - **Date of the Revised EUA** given (mm/dd/yy) _____/_____/_____, and I directed the client to the **QR Code.**

Vaccinator Signature: _____

FOR THE NURSE TO REVIEW WITH YOU

Check all that apply to you:

☐ Am a female between ages 18 and 49 years old

☐ Am a male between ages 12 and 29 years old

☐ Have a history of myocarditis or pericarditis

☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies

☐ Had Covid-19 and was treated with monoclonal antibodies or convalescent serum

☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a Covid-19 infection

☐ Have a bleeding disorder

☐ Take a blood thinner

☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies

☐ Have a history of heparin-induced thrombocytopenia (HIT)

☐ Am currently pregnant or breastfeeding

☐ Have received dermal fillers

☐ History of Guillain-Barré Syndrome (GBS)

Form Reviewed by Nurse_____ Date _____

NEW JERSEY DEPARTMENT OF HEALTH VACCINE PREVENTABLE DISEASE PROGRAM P.O. Box 369, Trenton NJ 08625-0369

609-826-4860 (Fax 609-826-4866) www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS) CONSENT TO PARTICIPATE

I have received information about the New Jersey Immunization System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies and others as permitted by New Jersey Law at N.J.S.A 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above. Yes, I would like to participate in this program.

Signature_____ **Date** _____

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CONSENT FOR VNA TO PROVIDE COVID-19 VACCINE ADMINISTRATION

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

_____

Recipient or Surrogate (Signature) **Date** **Print Name**