COVID-19 VACCINE SCREENING AND CONSENT FORM

Last name: _____ First name: _____

DOB: _____ Address: _____

City: _____ Zip: _____ Phone number: _____

Gender: _____ Ethnicity (Circle one): *Hispanic* *non-Hispanic*

Race (circle one): *Black/ African American* *White* *American Indian* *Asian* *other*

1. Are you sick today? (fever, cough, shortness of breath, nausea/vomiting, in last 24 hours) *Yes* *No*
2. Are you currently in your isolation or quarantine period due to COVID-19? *Yes* *No*
3. Have you ever had severe allergic reaction to anything (food, medication, vaccine, etc.)? *Yes* *No*
4. Have you received antibody therapy or convalescent plasma for COVID treatment in the past 90 days? *Yes* *No*
5. Have you received another vaccine in the past 14 days? *Yes* *No*

Sauk County Health Dept. participates in the Wisconsin Immunization Registry Program (WIR) by entering patient vaccinations. Participation in WIR is required for administration of the COVID-19 vaccine. By receiving this vaccine, you agree to allow Sauk County Health Dept. to input your vaccination record for COVID-19 into the WIR.

Mother's Maiden Name (First and Last): _____
(This information is needed to ensure that your information is entered into the correct immunization record).

I have been given a copy of the FDA Emergency Use Authorization Fact Sheet for the COVID-19 vaccine. I have read the fact sheet and have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of this vaccine and ask that the vaccine be given to me or the person for whom I am authorized to make this request.

Signature _____ Date: _____

FOR OFFICE USE ONLY

Place vaccine information sticker here

COVID-19 VACCINE INFORMATION
(Manufacturer/Lot number/Exp. date): _____

SITE OF INJECTION: ___ RIGHT DELTOID ___ LEFT DELTOID ___ 1ST DOSE ___ 2ND DOSE

SIGNATURE OF VACCINE ADMINISTRATOR: _____ DATE: _____