Community-Based Clinic: COVID-19 Vaccination Record & Consent

DO NOT RETURN THIS FORM IF YOU DECLINE VACCINATION

PARENT/LEGAL GUARDIAN INFORMATION (IF MINOR):
Full Name: _____ Daytime/Cell Phone Number: _____

VACCINE RECIPIENT INFORMATION:
Last Name: _____**First Name**: _____ **M.I.**___
DOB: _____/_____/_____ **Age:** _____
Mailing Address:
Street Address: _____Town/City: _____State: _____Zip: _____
Physical Address:
Street Address: _____Town/City: _____State: _____Zip: _____
Email Address (parent/guardian email if minor): _____
Cell Phone Number (parent/guardian number if minor): _____

Gender: ☐ Female ☐ Male ☐ Non-Binary ☐ Unknown/Not Reported
Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Unknown/Not Reported
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Other Race ☐ Native Hawaiian or Other Pacific Islander ☐ Unknown/Not Reported
Complete for Vaccine Recipient: Does the person being vaccinated currently have Medicaid, Well Sense, NH Healthy Families or AmeriHealth Caritas? ☐ Yes ☐ No

SCREENING QUESTIONS:

Please answer the questions below for the person who is receiving the vaccine to determine if there is any reason they should not get the COVID-19 vaccine. **If vaccine recipient is sick or unwell on the day of vaccination, they will not be vaccinated.**	**YES**	**NO**	**DON'T KNOW**
1. Have you ever received a dose of a COVID-19 vaccine before? If yes, please fill out dose table below and attach copy of record.	☐	☐	☐
2. Did you have an allergic reaction after a prior dose of any COVID-19 vaccine? (Allergic reactions can include symptoms like rash, hives, swelling of the face or mouth, wheezing and difficulty breathing, etc.) **If yes, please specify the specific vaccine AND your allergic reaction:**	☐	☐	☐ N/A ☐
3. Do you have a known allergy to an ingredient in the Pfizer-BioNTech COVID-19 vaccine, polyethylene glycol (PEG), or polysorbate? See the FDA Fact Sheet corresponding to your age included with this packet of information for a list of vaccine ingredients.	☐	☐	☐
4. Have you ever had any allergic reaction within 4 hours of receiving a non-COVID-19 vaccine or other injectable medication (including medications injected into a muscle, vein, or under the skin)?	☐	☐	☐
5. Have you ever had a severe allergic reaction (like anaphylaxis) due to any other cause, including to medications taken by mouth, food, or other substances?	☐	☐	☐

Recipient Last Name: _____ First Name: _____ M.I. _____

6. Did you develop myocarditis or pericarditis after receiving a prior dose of any COVID-19 vaccine?	☐	☐	☐
7. Have you ever been told you had a condition called "Multisystem Inflammatory Syndrome in Children" or MIS-C or called "Multisystem Inflammatory Syndrome in Adults" or MIS-A?	☐	☐	☐
8. Do you have a health condition that weakens your immune system and makes you moderately or severely immunocompromised?	☐	☐	☐
9. Have you received a COVID-19 vaccine or had a COVID-19 infection within the past 3 months?	☐	☐	☐

DOSE TABLE	PFIZER BIONTECH	MODERNA	JANSSEN	OTHER
DOSE 1 Date	____/____/_____	____/____/____	____/____/____	____/____/____
DOSE 2 Date	____/____/_____	____/____/____	____/____/____	____/____/____
DOSE 3 Date	____/____/_____	____/____/____	____/____/____	____/____/____
DOSE 4 Date	____/____/_____	____/____/____	____/____/____	____/____/____
DOSE 5 Date	____/____/_____	____/____/____	____/____/____	____/____/____

CONSENT AND NOTICES:

A copy of your/your child's vaccine record will be provided to you for your records. We recommend that you share a copy of this record with your/your child's healthcare provider. You may also choose to Opt-in to the NHIIS so that your provider may access the record electronically. Per NH RSA 141-C:20-f sharing your/your child's vaccine information with the NHIIS is voluntary and you are provided an opportunity to Opt-In (to share information) or Opt-Out (to not share information) prior to vaccination. No information will be shared with the NHIIS unless you have provided explicit consent to share your/your child's vaccine information.

☐ **I have been provided and reviewed information on the NH Immunization Information System (NHIIS).**
Available at: www.dhhs.nh.gov/programs-services/disease-prevention/immunizations/nh-immunization-information-system

NHIIS Consent: I choose to (check one):

☐ **Opt-In (share information)** I am consenting to share my/my child's vaccine information with the NHIIS.
Signature:_____

☐ **Opt-Out (do not share information)**

Immunization Consent: By signing below, I am acknowledging that I have received and reviewed the information provided, I have had any questions satisfactorily answered, and I understand the risk and benefits of receiving the influenza vaccine. By signing below, I also confirm that the information entered on this form is accurate and I GIVE CONSENT for the person named above (self or minor child) to be vaccinated with an age-appropriate influenza vaccine.

☐ **I have reviewed the COVID-19 Vaccine Information Statement**

Printed Name of Person Receiving Vaccine/Parent or Legal Guardian (if Minor):	
Signature of Person Receiving Vaccine/Parent or Legal Guardian (if Minor):	**Date:**

VACCINE RECIPIENT/PARENT/GUARDIAN - STOP HERE (ADMINISTRATIVE USE ONLY)

Recipient Last Name: _____ First Name: _____ M.I. _____

VACCINE ADMINISTRATOR MUST COMPLETE THE FOLLOWING SECTIONS:

<table>
<tr><td colspan="4">Clinic/School Name:</td></tr>
<tr><td colspan="3">BEFORE vaccinating, complete the following (check to confirm done):
☐ I have verified that the attached consent form has been signed by the vaccine recipient or parent/guardian (if minor)
☐ I have asked the recipient if they are feeling sick or unwell today (if vaccine recipient is sick, do NOT give vaccine)
☐ I have reviewed this form including the medical screening questions to identify potential vaccinate contraindications or precautions</td><td>☐ Recipient NOT vaccinated
Reason:
☐ Absent or did NOT attend clinic
☐ Refused the vaccine
☐ Incomplete consent form
☐ Other_____</td></tr>
<tr><td colspan="4">If vaccine recipient is sick or answers “yes” to any of the screening questions, STOP!
Vaccine may not be appropriate, or additional information may need to be collected from the parent/guardian.</td></tr>
<tr><td colspan="2">Administration Date:</td><td colspan="2">Administration Time:</td><td>Wait Time: ☐ 15 min ☐ 30 min</td></tr>
<tr><td colspan="2">Vaccine Name/Manufacturer:</td><td colspan="2">Lot Number:</td><td>Expiration Date:</td></tr>
<tr><td colspan="2">Route/Body Site:</td><td colspan="2">VIS Publication Date:</td><td>VIS Given Date:</td></tr>
<tr><td colspan="5">Provider Name & Address:</td></tr>
<tr><td colspan="5">Name and Title of Vaccine Administrator:</td></tr>
<tr><td colspan="5">Signature of Vaccine Administrator:</td></tr>
<tr><td>☐ NHIIS Opt In, Explicit Written Consent obtained</td><td>Date Entered into NHIIS:</td><td colspan="2">Entered into NHIIS By:</td><td>☐ NHIIS Opt Out, DO NOT Enter into NHIIS (record maintained by RPHN)</td></tr>
<tr><td>Needs Review: Yes ☐ No ☐</td><td colspan="3">After vaccination this form was reviewed by:</td><td>Review Completed Date (if applicable):</td></tr>
</table>