IMMUNIZATION REGISTRATION FORM

Please Print and Fill form out Completely

East Central District Health Department

I. CLIENT INFORMATION			
Today's Date:	**Language Preferred:**		
Patient's Last Name:	First:	Middle Initial:	Maiden Name (if married):
Sex: ❑ Female ❑ Male	Birth Date:	Age:	Mother's Maiden Name (First and Last):
Street Address:			Phone Number:
City:	State:	Zip:	County

II. CLIENT QUESTIONNAIRE – CHECK YES OR NO		
1. Do you have a fever, feel feverish or have you had COVID like symptoms in the past ten days?	❑ YES	❑ NO
2. Have you tested positive for COVID-19 in the past ten days?	❑ YES	❑ NO
3. Have you received monoclonal treatment or convalescent plasma in the past 90 days?	❑ YES	❑ NO
4. Do you have allergies to medications, food, yeast, egg, latex, thimerosal, phosphate, sucrose or any vaccine? If yes: _____	❑ YES	❑ NO
5. Have you ever had a serious reaction to a vaccine in the past?	❑ YES	❑ NO
6. Do you have a long-term health problem with heart, lung, kidney disease, asthma, diabetes, anemia, or other blood disorder?	❑ YES	❑ NO
7. Have you ever had a seizure, neurological problem, or Guillain-Barre syndrome?	❑ YES	❑ NO
8. Do you have cancer, leukemia, AIDS, or any other immune system illness?	❑ YES	❑ NO
9. In the last 3 months have you taken cortisone, prednisone, other steroids, anticancer medication, or X-ray treatment?	❑ YES	❑ NO
10. Have you received a transfusion of blood, plasma, or medicine called immune globulin or an antiviral drug in the past year?	❑ YES	❑ NO
11. Do you have a bleeding disorder or are on a blood thinner?	❑ YES	❑ NO
12. (Females) Are you pregnant or thinking about becoming pregnant within the next 3 months?	❑ YES	❑ NO
13. (Females) Are you currently breastfeeding?	❑ YES	❑ NO
14. Have you received any vaccinations in the past 4 weeks?	❑ YES	❑ NO

CONSENT

By signing this document:

- I acknowledge that the East Central District Health Department (ECDHD) has made their Notice of Privacy Practices available for my review.
- I have read or had explained to me the Emergency Use Authorization (EUA) for the vaccine that is planned to be given.
- I have received a copy of the Fact Sheet for Recipients and Caregivers
- I give permission for myself or the minor child to receive immunizations.
- I give consent and authorization for the release of health information related to immunizations

X_____

AUTHORIZED SIGNATURE (CLIENT, IF UNDER THE AGE OF 19 – PARENT/LEGAL GUARDIAN)
TODAY'S DATE

FOR CLINIC / OFFICE USE ONLY :

Name of Vaccine, Manufacturer:	Date Vaccine Administered:
Vaccine Expiration Date:	Vaccine Lot Number:
Site of Injection:	Date VIS Given:
Signature of Vaccine Administrator:	