DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Immunization Program

Immunization Reporting Record

All Sections Required	
Practice Name(1) :	
Ordering Provider(2):	**Administering Provider**(3):
Patient Information	
Patient's Name (Last, First)(4):	**Sex** (6): □Male □Female
Patient's Address(5):	**DOB** (7): / / If under 18, parent/guardian must sign below
	Ethnicity (8): □Hispanic □Non-Hispanic
City, State Zip Code:	
RACE - Select all that apply(9) : ☐Caucasian/White ☐African American/Black ☐Am. Indian/Alaskan Native ☐Asian ☐Hawaiian or Other Pacific Islander ☐Other (Specify):	

Email: _____

Phone: _____ **Do you have a physical disability?** ☐ Yes ☐ No

COVID Vaccine Information: Please Print

Vaccine Date (MM/DD/YYY) | **Manufacturer**

Vaccine Expiration Date (MM/DD/YYY) | **Lot Number**

VIS/EUA Date (MM/DD/YYY)

Site (Check One): RD___ LD___ RA___ LA___ RT___ LT___

Route (Check One): IM___ IT___ ID___ NS___ PO___ SC___

Priority Group / Phase

Complete the next section and sign after you have talked with the clinician.

Vaccine to be administered : O First Vaccine Shot *OR* O Second Vaccine Shot

A filled in circle next to the vaccine (above) and my signature (below) means that I have been provided a copy of the appropriate Vaccine Information Statement and have read, or have had explained to me, information about the disease and the vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I understand the risks and benefits as set forth in the statement received and I ask that the vaccine, as marked, be given.

Signature _____ Signer's Name _____

O Patient **If Patient Under 18:** O Parent O Guardian Print Clearly

Screening Questionnaire for 2020 COVID-19 Vaccination

The following questions will help us determine if there is any reason, we should not give you 2020 COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you or your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your clinician.

Please check the appropriate boxes below.

Patient Age: _____

	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 the 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, polysorbate, 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?			
13. Have you experienced fainting, dizziness or light-headedness after any previous vaccinations or other skin injections (such as IV insertion or blood donation)?			