DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Immunization Program

Immunization Reporting Record

All Sections Required		
Practice Name:		
Ordering Provider:	**Administering Provider:**	
Patient Information		
Patient's Name (Last, First):	**Sex:** □Male □Female	
Patient's Address:	**DOB:** / /	If under 18, parent/guardian must sign below
	Ethnicity: □Hispanic □Non-Hispanic	
City, State Zip Code:		
RACE - Select all that apply:	☐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 ___

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

Vaccine to be administered: O **First Vaccine Shot** O **Second Vaccine Shot** O **Third 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 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 one 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			
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. Check all that apply to you			
☐ Am a female between 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 weakened immune system (i.e., HIV infection, cancer)			
☐ Take immunosuppressive drugs or therapies			
☐ Have a bleeding disorder			
☐ Take a blood thinner			
☐ Have a history of heparin-induced thrombocytopenia (HIT)			
☐ Am currently pregnant or breastfeeding			
☐ Have received dermal fillers			