Public Health
Prevent. Promote. Protect.
Traill District Health Unit

COVID-19 VACCINE ADMINISTRATION RECORD

Traill District Health Unit

NDIIS Provider ID: 40

Information collected on this form will be used to document authorization for receipt of vaccine(s). Information may be shared through the North Dakota Immunization Information System (NDIIS) with other entities in accordance with North Dakota Century Code 23-01-05.3.

<table>
<tr><td colspan="3">Patient's Name (Last, First, Middle):</td><td rowspan="3">Race: (Check Box)
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other
☐ Unknown</td></tr>
<tr><td>Hispanic or Latino:
☐ Yes
☐ No</td><td>Date of Birth:</td><td>Age:</td></tr>
<tr><td>Gender:
☐ Male
☐ Female</td><td>Primary Telephone No.:</td><td>Telephone Number Type:
☐ Home ☐ Mobile
☐ Work</td></tr>
<tr><td colspan="2">Address (Street or P.O. Box):</td><td>City:</td><td>State: ZIP Code:</td></tr>
<tr><td colspan="2">County:</td><td colspan="2">Birth State or Birth Country (If not U.S.):</td></tr>
<tr><td colspan="2">Mother's Name: Last, First, Middle (If younger than 18 years)</td><td colspan="2">Mother's Maiden Name: (If younger than 18 years)</td></tr>
</table>

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any of the following questions, it does not necessarily mean you should not be vaccinated today. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain.

			Clinic Staff Use Only	
Question	**Yes**	**No**	**Dose #1**	**Dose #2**
Have you had a severe allergic reaction (e.g., anaphylaxis) to a previous vaccine or other injectable therapy?	If yes, please specify:			
Have you had a severe allergic reaction (e.g., anaphylaxis) to food, medicine, or other?	If yes, please specify:			
Have you received any vaccines in the past fourteen days?				
Have you tested positive for COVID-19?	If yes, when?			
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment within the past 90 days?				
Do you currently have a fever?				
Do you have a bleeding disorder or are on a blood thinner?				
Are you pregnant, planning to become pregnant or breastfeeding?				

A copy of the appropriate Emergency Use Authorization Face Sheet has been provided. I have read, or have had explained, the information about the disease and the vaccine listed below. There was an opportunity to ask questions and all questions were answered satisfactorily. I believe that I understand the benefits and risks of the vaccine cited and ask that the vaccine listed below be given to me or to the person named above (for whom I am authorized to make this request).

I consent to receive the vaccine provided. (Signature of patient or parent/guardian).	**Date:**

DO NOT WRITE BELOW THIS LINE

Priority Groups for COVID Vaccine (Check all that apply):

___ Healthcare personnel (i.e. paid and unpaid personnel working in healthcare settings, local public health personnel, long term care staff)
___ Essential worker (i.e. emergency medical services, education, fire, law enforcement, utility, energy, etc.)
___ 75 or older
___ Adult aged 65 years or older
___ Underlying health condition (i.e. COPD, heart disease, diabetes, chronic kidney disease, obesity)
___ Live-in other congregate setting
___ Other

Dose #	COVID Vaccine Presentation	EUA Fact Sheet Date	Route[1]	Manufacturer[2]	Lot Number	Admin Site[3]	Person Admin[4]
1	COVID-19 (Pfizer)		IM	PFR			
2	COVID-19 (Pfizer)		IM	PFR			
1	COVID-19 (Moderna)		IM	MOD			
2	COVID-19 (Moderna)		IM	MOD			

Dose #1 Signature and Title of Person Administering Vaccine:	**Date Administered:**
Dose #2 Signature and Title of Person Administering Vaccine:	**Date Administered:**

1. **Route:** IM = Intramuscular
2. **Manufacturer:** MOD = Moderna, PFR = Pfizer
3. **Site Vaccine Given:** LA = Left Arm, RA = Right Arm, LT = Left Thigh, RT = Right Thigh
4. **Signature or initials of person administering vaccine:** Can be used if more than one person is administering vaccines

This area to be used for recording additional information that did not fit in the spaces of the form above. If you are NOT the nurse administering the vaccination today as signed above please sign your name, title and date at the end of your entry. If you are the nurse administering the vaccination today please initial and date the end of your entry.

Revised: 1-22-2021