Date____________________

COVID-19 Vaccine Administration Record

Harney County Health Department
420 N Fairview Ave
Burns Oregon 97720
541-573-2271
Fax 541-573-8388

Patient Information

Last Name: ____________________ First Name: ________________ Middle Name: ____________

Date of Birth: ________________ Gender: Male ☐ Female ☐

Address: ____

Mailing Address: ____

Phone Number: ________________ Mother's Maiden Name (optional): ____________________

Race: (Check all that apply) African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Decline to Answer ☐

Ethnicity: Hispanic? Yes ☐ No ☐ Decline ☐ Primary Language: ____________________

Social Security Number (optional): ________ — _____ — ________ Medicaid ID Number (optional): ____________

Primary Insurance________________ Insurance ID#____________________ Group #______________

☐ I have received this clinic's HIPAA Notice of Privacy Practices

Patient Screening Questions

	Select one:		
Do you have a fever or feel sick today?	Yes ☐	No ☐	
Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? Pfizer Moderna Other	Yes ☐	No ☐	Don't know ☐
Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?	Yes ☐	No ☐	Don't know ☐
Was the severe allergic reaction after receiving a COVID-19 vaccine?	Yes ☐	No ☐	Don't know ☐
Was the severe allergic reaction after receiving another vaccine or another injectable medication?	Yes ☐	No ☐	Don't know ☐
Have you received another vaccine in the last 14 days?	Yes ☐	No ☐	
Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	Yes ☐	No ☐	Don't know ☐
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	Yes ☐	No ☐	Don't know ☐
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	Yes ☐	No ☐	
Do you have a bleeding disorder or are you taking a blood thinner?	Yes ☐	No ☐	
Has the patient ever fainted after injections?	Yes ☐	No ☐	
Are you pregnant or breastfeeding?	Yes ☐	No ☐	