Iredell County Health Department

COVID-19 Vaccine Registration Form

Registration Personnel complete **section 1**:

Print Name: _____ _____

First Last

Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Phone #: _____

E-mail: _____ Preferred method of contact: □ Text (SMS) □ E-mail □ None

Date of Birth: _____ Age: _____ Gender: □ Male □ Female □ Other: _____

Race: □ Black or African American □ White □ Asian □ Other: _____

Ethnicity: Hispanic or Latino- □ Yes □ No

Allergies to any medications? □ Yes □ No- if yes, list: _____

1. Are you a healthcare worker or public health responder with high risk for exposure to COVID-19? (EMS, funeral home staff, public safety, environmental services, etc.)- □ Yes □ No
   If yes, name of employer:
   _____
2. Do you reside or work in a long-term care/assisted living facility? □ Yes □ No
   If yes, name of facility:
   _____
3. Are you a member of a state or federal recognized tribal nation? □ Yes □ No
   If yes, name of community:
   _____
4. How many high-risk chronic conditions do you have? (cancer, kidney disease, COPD, heart condition, weakened immune system from solid organ transplant, obesity, pregnancy, smoking, diabetes- **see full list below**)- □ None □ 1 □ 2 or more
5. Are you feeling sick today? □ Yes □ No- can receive vaccine if only a mild illness
   If #6 or #7 "yes," can't receive the vaccine today. If #8 "yes," needs a Dr. Note:
6. Have you received any vaccines in the past 14 days? □ Yes □ No
7. Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days? □ Yes □ No
8. Do you have a bleeding disorder or are you taking a blood thinner? □ Yes □ No

MEDICAL INFORMATION

Review the below list of conditions known to increase risk of severe illness to COVID-19:

- Asthma
- Cancer
- Cerebrovascular Disease
- Chronic Obstructive Pulmonary Disease
- Chronic Kidney Disease
- Cystic Fibrosis
- Hypertension or High Blood Pressure
- Type 1 Diabetes Mellitus
- Type 2 Diabetes
- Immunocompromised from solid organ transplant
- Immunocompromised state (weakened immune system)
- Liver Disease
- Neurologic conditions, such as Dementia
- Obesity
- Overweight (BMI > 25 kg/m2, but < 30 kg/m2)
- Pregnancy
- Pulmonary Fibrosis (having damaged or scarred lung tissues)
- Sickle Cell Disease
- Smoker
- Thalassemia (a type of blood disorder)

Vaccinator to complete **section 2:**

Females:

Are you pregnant? □ Yes □ No

□ If yes, explained that there are no data on the safety of COVID-19 vaccine in pregnant women. Should discuss with physician prior to vaccination if questions or concerns.

Are you breastfeeding? □ Yes □ No

□ If yes, explained that that there are no data on the safety of COVID-19 vaccine in breastfeeding women or on the effects on the breastfed infant or milk production/excretion. Should discuss with physician prior to vaccination if questions or concerns.

All recipients:

□ The following handouts were given and were reviewed by the individual/caregiver prior to vaccination:

- COVID-19 Vaccine Eligibility, Contraindications, and Precautions
- Fact Sheet for Recipients and Caregivers Emergency Use Authorization (EUA) of the Moderna COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19 in Individuals 18 years of age and Older
- V-safe after vaccination health checker information

Question: Have you ever had an anaphylactic reaction to any vaccine or injectable therapy?
□ Yes □ No; If yes, instruct that observation period after vaccination is 30 minutes.

□ Instructed not to receive another vaccine within 14 days of receiving COVID vaccine.

□ Encouraged to remain in observation area for 15 minutes; 30 minutes if history of an anaphylactic reaction to any vaccine or other injectable therapy.

□ Instructed to contact a healthcare provider immediately if symptoms of allergic reaction occur, including shortness of breath, hoarseness, wheezing, hives, paleness, weakness, elevated heart rate, or severe dizziness.

□ **Verbal consent:** The benefits of vaccination and potential adverse reactions, including severe allergic reaction, have been explained to the individual/caregiver and they have provided verbal consent to receive the vaccine. Nurse initials: _____

Administered by: _____ Title: _____

Date: _____ Time: _____ Site: RD_____ LD_____ RVL_____ LVL _____

Vaccine Product: COVID-19 □ ***Dose #1*** □ ***Dose #2***
Manufacturer: Moderna TX
NDC: 80777-0273-99

Select Lot # given: ☐ 039K20A Exp. 6/20/21 ☐ 011L20A Exp. 7/3/21 ☐ 012L20A Exp. 7/6/21

□ If first dose, instructed to return for 2nd dose in *28 days

***Note: The second dose should be given as close as possible to the target date, but if target date is missed there is no need to restart or repeat any doses. Not to be given earlier than day 24 after the first vaccine.**