Health, Housing & Human Services
CLACKAMAS COUNTY

COVID-19 VACCINE ADMINISTRATION RECORD

Clackamas County Public Health
Immunization Program
999 Library Ct., Oregon City, OR 97045
Clinic site: ______________________

Patient Name Last: ________________________ First: ______________________ Middle: ____________

Date of Birth: _______________________ Age: ______ Years

Gender: ❑ Male ❑ Female ❑ Other ❑ Decline to answer

Address Type: (Check one or both) ❑ Home ❑ Mailing

Address: ____ Apt #: ____________

City: ________________State:_____ Zip: __________ Phone Number: ______________________________

Email address (for second appointment): ________________________ Language preference:__________________

Patient Screening Questions			
	Circle 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 or hives/swelling/difficulty breathing) to something that required treatment with epinephrine or EpiPen®, or for which you had to go to the hospital?	Yes	No	Don't know
Have you ever had a severe allergic reaction or anaphylaxis to any of the following:			
• A previous dose of the COVID-19 vaccine?	Yes	No	Don't know
• Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures?	Yes	No	Don't know
• Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids?	Yes	No	Don't know
• Another vaccine (other than COVID-19 Vaccine), or any injectable medication?	Yes	No	Don't know
• Anything else including: oral medication, food, pet, bee sting, etc…?	Yes	No	Don't know
Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	Yes	No	
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	Yes	No	
Have you been diagnosed with multisystem inflammatory syndrome in children (MIS-C)?	Yes	No	
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	
Do you have a history of or a risk factor for a blood clotting disorder?	Yes	No	
Have you had a blood clot diagnosed in the last 6 months?	Yes	No	
Have you ever fainted after an injection?	Yes	No	
Are you pregnant or breastfeeding?	Yes	No	

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Patient Consent/Demographic Information

I have received the Emergency Use Authorization fact sheet for the vaccine to be given and I have had all of my questions answered. I consent that the vaccine be given to me or to the person named above, for whom I am an authorized representative. If signing on behalf of a minor, I attest that the person receiving the vaccine is 12 years of age or above. I consent to the release of any information needed to process insurance claims and request payments of medical benefits.

Print name: ____

Signature: ____

If not patient, relationship to patient: ______________________________

Date: ____

Patient race: (Check all that apply) ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/ African American ❑ Native Hawaiian/ Pacific Islander ❑ White ❑ Other/Decline to answer

Patient ethnicity: Hispanic? ❑ Yes ❑ No ❑ Unknown

FOR CLINIC USE ONLY

Dose #	Vaccine	Brand Name	Lot Number	Exp.	Manuf.	Dose (ML)	Site/ Route	Elig.	EUA Pub Date	EUA VIS Given
	COVID-19				Pfizer-BioNTech	0.3		S	12/2020 05/2021	
					Moderna	0.5		S	12/2020 03/2021	
n/a					J & J	0.5		S	02/2021 04/2021	

Vaccine Administrator Signature:____________________Title:___________________Date: ________________

Vaccine site/route codes:
LAIM- left arm intramuscular
RAIM- right arm intramuscular