POD COVID-19 Vaccine Administration Form

Patient Information

Full Legal Name _____

Date of Birth _____ Gender: ☐ Male ☐ Female

Race _____ Ethnicity _____

Other Names Used (e.g. maiden name): _____

Parent/Guardian First and Last Name (if patient is under age 18) _____

Address _____ City _____ State _____ Zip _____

Phone Number _____

Please answer the following questions:

1. Have you received treatment for COVID-19? ☐ No ☐ Yes
2. In the past 14 days have you received any type of vaccine or do you plan to receive a vaccine other than for COVID-19 in the next 14 days? ☐ No ☐ Yes
3. Are you pregnant, lactating or planning to become pregnant? ☐ No ☐ Yes
4. Do you have a history of anaphylactic reactions? ☐ No ☐ Yes
5. Are you immunocompromised or taking a medication to suppress your immune system? ☐ No ☐ Yes
6. Are you able to take other vaccines, like influenza or shingles? ☐ No ☐ Yes

☐ **YES,** I would like the COVID-19 vaccine given to myself. I have been provided with the opportunity to read the COVID-19 fact sheet for recipients and caregivers.

Signature _____ Date _____

For Vaccinator Use Only

Vaccine Manufacturer _____ Lot # _____ Expiration Date _____

Administered By _____ Administration Date _____

Time of Administration _____ Time of Departure _____

Site of Administration: L R Deltoid

American Red Cross

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South Dakota State University

Brookings County South Dakota

Brookings HEALTH SYSTEM