McDonough District Hospital
525 E Grant Macomb, IL 61455
309-833-4101

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 questions, it does not necessarily mean you should not be vaccinated.** It just means additional question may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Patient Information:

Legal Last Name	**Legal** First Name	MI	Maiden Name	Date of Birth	M / F Gender

Address City State Zip

Phone _____ E-mail Address_____

Race: _____American Indian or Alaska Native _____Asian _____Black _____Refused
_____Native Hawaiian/Pacific Islander _____White _____Other race _____Unknown

Ethnicity: _____Not Hispanic/Latino _____Hispanic/Latino

Is this the patient's first ___ or second ___ dose of the COVID-19 vaccination? **Temp_____**

	YES	NO	Unsure
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• Which vaccine product? ___Moderna ____Pfizer			
3. 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?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

CONSENT FOR SERVICES: I have been provided and reviewed the COVID fact sheet. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that my result. I understand that I should remain in the vaccine monitoring area for 15 minutes or as directed after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: contact doctor, call 911. I understand that a second dose of the vaccine will be required, and I agree to return for the 2nd dose. I consent to receiving a text message reminding me of my 2nd dose. I request that the COVID vaccine be given to me.

DISCLOSURE OF RECORDS: I understand that it is required to report individuals vaccinated to the local Health Department for entry into state registry.

Signature_____Date_____

VACCINE ADMINISTRATION INFORMATION

Lot #:	**Exp. Date:**	**Route IM**	**Site L / R**	**Pfizer 0.3mL** **Moderna 0.5 mL**

Signature of Immunizer Name & Title_____Date_____