COVID-19 VACCINATION RECORD

785-864-9000

FIRST Name: _____LAST Name:_____

Date of birth: ____/____/____ Age:____ Gender:_____ Race:_____ Hispanic/Latino: Yes or No Telephone: _____

Address: _____ City: _____ State: _____ Zip:_____

Doctor/Primary Care Provider: _____ City:_____

I would like to receive the following Immunization(s):
□ Covid-19 FIRST DOSE □ Covid-19 SECOND DOSE

ALL VACCINES

1. Are you sick today (fever, vomiting, diarrhea)?	□ Yes □ No □ I don't know
2. Have you ever received a dose of Covid-19 vaccine? **If yes**, which vaccine product?	□ Yes □ No □ I don't know □ Pfizer □ Moderna □ Johnson and Johnson
3. Do you have any allergies to medication, food, vaccines, or latex?	□ Yes □ No □ I don't know
4. Have you ever had a serious reaction after receiving a vaccination?	□ Yes □ No □ I don't know
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?	□ Yes □ No □ I don't know
• Was the severe allergic reaction after receiving a COVID-19 vaccine?	□ Yes □ No □ I don't know
• Was the severe allergic reaction related to receiving Polyethylene Glycol or products containing Polyethylene Glycol?	□ Yes □ No □ I don't know
• Was the severe allergic reaction related to receiving Polysorbate or products containing Polysorbate?	□ Yes □ No □ I don't know
5. Do you have a long-term health problem like heart disease, lung disease, asthma, kidney disease, diabetes, anemia, or other blood disorder?	□ Yes □ No □ I don't know
6. Do you have a seizure disorder, brain disorder, or nervous system problem?	□ Yes □ No □ I don't know
7. Have you received any vaccines in the past 14 days?	□ Yes □ No □ I don't know
8. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?	□ Yes □ No □ I don't know
9. Do you have a bleeding disorder or are you taking a blood thinner?	□ Yes □ No □ I don't know
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	□ Yes □ No □ I don't know

I have been offered a copy of the "Vaccine Information Statement(s)" checked below. I have read, have had explained to me and understand, the information in the "Vaccine Information Statement(s)". I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am the parent or guardian or am otherwise authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself and on behalf of the person named below.

*****Signature***: _____ Date:_____**

Vaccine (Manufacturer)		Dosage	Site	NDC	Lot#	Expiration	VIS date
□ MODERNA Covid-19 Vaccine	IM	0.5mL	L / R				
□ PFIZER Covid-19 Vaccine	IM	0.3mL	L / R				
□ JOHNSON AND JOHNSON Covid-19 Vaccine	IM	0.5mL	L / R				

Immunizer name:_____ Immunizer signature:_____

Intern name (if applicable): _____ Administration date:_____