COVID-19 Vaccination Administration Form

Section 1: To be completed by Client or Parent/Legal Guardian (if client less than 16 years of age)

Name:	Date of Birth:	Age:	Race:	Sex:
Street Address:	**Telephone:** ☐Cell ☐ Home			
City/State:	**County:**		**Zip:**	
Preferred Method of Contact: ☐Call ☐Mail	**Preferred Phone/Address (if different from above):**			
Emergency Contact:	**Emergency Phone:**			

THE FOLLOWING QUESTIONS APPLY TO THE PERSON BEING VACCINATED:	YES	NO
1.Are you feeling sick today or have you tested + for COVID in the last 2 weeks?		
2.Have you received a previous dose of COVID-19 vaccine? If yes, list the dates and manufacturers: Dose #1: ________________ Dose #2: ________________ Dose #3: ________________		
3. Have you ever had an allergic reaction to a previous dose of COVID-19 vaccine or to any component of the COVID-19 vaccine, such as polyethylene glycol (PEG) or polysorbate?		
4.Have you ever had an allergic reaction for which you received epinephrine (EpiPen) or were seen in the hospital? Please Explain________________		
5.Have you received COVID monoclonal antibodies or convalescent plasma in the last 90 days?		
6.Do you have a bleeding disorder or are you taking a blood thinner?		
7. Do you have a history of one of the following conditions? • Multisystem Inflammatory Syndrome (MIS-Child or MIS-Adult) • Myocarditis/pericarditis (including following previous mRNA COVID-19 vaccine)		
8. Do you have a history of dermal fillers? (Provide standing order discharge instructions for dermal fillers)		
9. Do you have a history of Guillain-Barre Syndrome? (see **Janssen Precautions**, if applicable)		
10. Do you have a history of thrombosis with thrombocytopenia? (see **Janssen Precautions**, if applicable)		
11.Do you have any of the following medical condition(s)? **(Pfizer and Moderna- dose #3 ≥ 28 days)** • Active treatment for solid tumor and hematologic malignancies • Receipt of solid-organ transplant and taking immunosuppressive therapy • Receipt of CAR-T-cell or hematopoietic stem cell transplant (2 years of transplantation or taking immunosuppression therapy) • Moderate or severe primary immunodeficiency (e.g., DiGeorge, Wiskott-Aldrich syndromes) • Advanced/untreated HIV infection, active treatment with high-dose corticosteroids (i.e., ≥20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemo agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, other biologic agents that are immunosuppressive or immunomodulatory		
12. Do you have one of the following conditions and have completed the Pfizer or Moderna 2-dose primary vaccination series? **(Pfizer and Moderna ONLY- dose #3 booster ≥ 6 months)** • 65 years of age and older • Resident of a long-term care facility • 18 years of age and older with cancer, chronic kidney disease, chronic lung disease, dementia or other neurologic conditions, diabetes, down syndrome, heart conditions (including, but not limited to, heart failure, coronary artery disease, cardiomyopathies, and hypertension), HIV, liver disease, overweight/obesity, pregnancy, sickle cell disease or thalassemia, current or former smoker, solid organ or stem cell transplant, stroke or cerebrovascular disease, or substance abuse • Individuals 18 years of age or older who are at increased risk for COVID-19 exposure and transmission because of occupational orinstitutional setting		

I have completed SECTION 1. By my signature below as client, parent, legal guardian, or other responsible party, I attest that all the information provided is complete and accurate. I am aware of the risks associated with getting more than the recommended dose(s). I understand that depending on my immunization history, I may not be considered fully vaccinated. I hereby give my consent to and authorize South Carolina Department of Health and Environmental Control employees and agents to provide immunization services and medical care to me or, in case of a parent or legal guardian, to my child or ward.

Client/Parent/Legal Guardian Signature (if client less than 16 years of age): ________________________________**Date:** ____________

Relationship to Person Receiving Vaccine: ________________________________

Vaccine Name	Dosage	Dose	Site	Route	Lot #	Manufacturer	EUA Fact Sheet
Moderna COVID-19 Vaccine	☐0.5ml ☐0.25ml (booster)	☐1 ☐2 ☐3	☐LA ☐ RA ☐LL ☐ RL	IM		Moderna	☐ Fact sheet provided
Pfizer- BioNTech COVID-19 Vaccine Children 5-11 years of age	☐0.3ml ☐0.2ml	☐1 ☐2 ☐3	☐LA ☐ RA ☐LL ☐ RL	IM		Pfizer	☐Fact sheet provided
Janssen COVID-19 Vaccine	0.5ml	☐1 ☐2	☐LA ☐ RA ☐LL ☐ RL	IM		Janssen	☐Fact sheet provided

Signature/Title of Person Administering Vaccine:	**Date/Time:**
Clinic Site or Health Department:	VAMS Entry Complete: ☐

COVID-19 Vaccination Form
INSTRUCTIONS FOR COMPLETING

Purpose

To provide demographic information, COVID-19 vaccine history, screening, and immunization documentation for administered COVID-19 vaccine in the event of the inability to access the Vaccine Administration Management System (VAMS).

***SECTION I**: To be completed by Client or Parent/ Legal Guardian (if client is less than 16 years of age)*

Demographics

- Complete boxes with appropriate information.
- DHEC staff to record assigned MCI number.

Screening.

- Complete screening questions.

Signature

- Sign and date form and indicate relationship to client (if applicable).

***SECTION II**: To be completed by DHEC staff*

Documentation

- Complete the dosage, dose number, site, and lot number for the vaccine administered.
- Check the appropriate box in cells where check boxes are available.

Signature and Site (DHEC staff)

- Sign (including title), date, and time the form.
- Record the clinic site/ health department

IIS Entry

- Enter administered vaccine or immune globulin into the VAMS system and check the box to confirm entry.

Office Mechanics

- Forms should be batch filed by year and applicable health record retention schedule (8498 - Adult Comprehensive Health Record and 8499 - Minor Comprehensive Health Record). Records must be maintained in the health department's medical records room or other designated secure area.