Vaccine Registry Data Collection Form

PLEASE CARRY THIS FORM WITH YOU THROUGHOUT THE VACCINATION CLINIC
IT WILL BE COLLECTED FROM YOU AT CHECKOUT

REGISTRATION INFORMATION
To be completed by the Vaccine Recipient

Vaccine Recipient Name (Last, First, MI): _____

Address: _____ Town: _____State: ____ Zip: _____

Phone Number: _____ Email address: _____

Date of Birth (MM/DD/YYYY): _____

Gender:
- ☐ Male
- ☐ Female
- ☐ Other

Ethnicity:
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

VACCINE ADMINISTRATION INFORMATION
To be completed by Clinic Staff

Vaccinator Name: _____

Vaccine Product: _____ Dose #: ☐ 1st ☐ 2nd ☐ 3rd ☐ Booster

Lot #: _____ Expiration Date: ____/____/_____

Administration Date: _____ Administration time (HH:MM): _____

Administration Site: ☐ L Arm (LA) ☐ L Deltoid (LD) ☐ L Anterior Lateral Thigh (LALT)

☐ R Arm (RA) ☐ R Deltoid (RD ☐ R Anterior Lateral Thigh (RALT)

NH DIVISION OF Public Health Services
Department of Health and Human Services

Bureau of Infectious Disease Control

Pre-Vaccination Screening Questions for Persons 18 Years of Age or Older

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine. If you answer "yes" to any of the questions, it does not necessarily mean you should not be vaccinated. It just means additional information may be needed. Please answer the questions below for the person who is receiving the vaccine.

Name of Person Receiving the Vaccine: _____

Date of Birth: _____ **Age:** _____

COVID-19 Vaccine Being Administered: ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen (Johnson & Johnson)

		Yes	No	Don't Know
1.	Are you feeling sick today?	☐	☐	☐
2.	Have you ever received a dose of a COVID-19 vaccine before? **<u>If yes</u>**, which COVID-19 vaccine product(s) were you previously given? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen (Johnson & Johnson)	☐	☐	☐
3.	Did you have an allergic reaction after a prior dose of any COVID-19 vaccine? (*Allergic reactions can include symptoms like rash, hives, swelling of the face or mouth, wheezing and difficulty breathing, etc.*) **<u>If yes</u>**, please specify the specific vaccine AND your allergic reaction: _____	☐	☐	☐
4.	Do you have a known allergy to an ingredient in the COVID-19 vaccine that you will be receiving today? *(See the provided FDA Fact Sheet for a list of vaccine ingredients)*	☐	☐	☐
5.	Do you have a known allergy to polyethylene glycol (PEG)?	☐	☐	☐
6.	Do you have a known allergy to polysorbate?	☐	☐	☐
7.	Have you ever had any allergic reaction within 4 hours of receiving a non-COVID-19 vaccine or other injectable medication (including medications injected into a muscle, vein, or under the skin)?	☐	☐	☐
8.	Have you ever had a severe allergic reaction (like anaphylaxis) due to any other cause, including to medications taken by mouth, food, or other substances?	☐	☐	☐
9.	Did you develop myocarditis or pericarditis after receiving a prior dose of either the Pfizer-BioNTech or Moderna COVID-19 vaccine?	☐	☐	☐
10.	Do you have a bleeding disorder or are you taking blood thinners?	☐	☐	☐
11.	In the last 90 days, have you been given a COVID-19 antibody therapy to either treat COVID-19, or to prevent COVID-19 from developing after you were exposed to another person with COVID-19? (*Antibody therapies include monoclonal antibodies or a blood product called "convalescent plasma"*)	☐	☐	☐
12.	In the last 90 days, did you develop an immune-related health condition that caused blood clotting AND low platelet blood counts? (T*he most common example of this is called "heparin-induced thrombocytopenia"*)	☐	☐	☐
13.	Did you develop a health condition called "thrombosis with thrombocytopenia" (TTS) after receiving a prior dose of the Janssen vaccine? (*People with this syndrome develop blood clotting and low platelet blood counts after receiving the Janssen vaccine*)	☐	☐	☐
14.	Did you develop Guillain-Barré syndrome (GBS) after receiving a prior dose of the Janssen vaccine?	☐	☐	☐

Please sign below to confirm that the information on this form is accurate to the best of your knowledge:

Signature of Vaccine Recipient: _____

Date: _____