

COVID-19 VACCINE QUESTIONNAIRE/DOCUMENTATION FORM

I have been offered a copy of the COVID-19 Emergency Use Authorization (EUA). I have read, had explained to me, and understand the information in the EUA. I acknowledge that my vaccine information will be entered into the Kansas Immunization Registry (WebIZ). I understand that the Notice of Privacy Practice is available on the LDCPH website.

Please **PRINT** information about person to receive vaccine.

Name:		Birthdate:	Phone Number:
Street Address:		City:	State:
Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic/Latino	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other, Not listed
<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Other			

Type of insurance: Medicare KanCare/Medicaid Other (please list company): _____

Policy # _____ Policyholder: Self or Please list: _____

Email address: _____ Policyholder DOB _____

Relationship to Patient _____

Questions apply to the person receiving the COVID -19 vaccine

Select Yes or No

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Are you 18 year of age or older? | Yes | No |
| 2. Are you ill today or do you have a fever? | Yes | No |
| 3. Have you ever had an anaphylactic or serious reaction (shortness of breath, hives, throat swelling) to any vaccine, injectable medication or other substance? | Yes | No |
| 4. Have you received any vaccine in the past 14 days? | Yes | No |
| 5. Have you received monoclonal antibody treatment for Covid 19 illness in the last 90 days? | Yes | No |

X _____ Date: _____

SIGNATURE of Client /Client Representative

FOR HEALTH DEPARTMENT USE ONLY

For Vaccine Administrator Use Only

Vaccine Code	Site	Dose/Route	Lot Number	Exp. Date
Moderna	LD	0.5mL	EL9264	12/31/2069
Pfizer	RD	0.3 mL		

_____ Provider Signature