THREE RIVERS
PUBLIC HEALTH DEPARTMENT
Dodge, Saunders & Washington Counties

Three Rivers Public Health Department

Lot #:_____
Site:_____
Nurse:_____
Dose: 1st 2nd
3rd/booster 4th/booster

COVID-19 VACCINE REGISTRATION FORM

Last Name	First Name	Middle Initial	Maiden Name
Address	City	State	Zip
Date of Birth ___/___/____	Age	Country of Birth	County of Residence
Gender: ☐ Male ☐ Female	Phone (___) ____ - _____	E-Mail address	Name of Physician

Ethnicity: ☐White ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Alaska Native ☐ Hispanic or Latino

Answer the Following Client Health Questions

1.	Is the recipient at least 19 years of age?	☐ **Yes**	☐ **No**
2.	If the recipient is under 19, are they at least 5 years of age with a parent or guardian present?	☐ **Yes**	☐ **No**
3.	Is the recipient currently sick?	☐ **Yes**	☐ **No**
4.	Has the recipient ever had a serious allergic reaction to a vaccine or vaccine component such as polyethylene glycol or polysorbate, including a previous dose of a COVID-19 vaccination?	☐ **Yes**	☐ **No** **Date:** _____
5.	Has the recipient ever had a serious allergic reaction to something other than a vaccine or vaccine component, such as food, pets, venom, or environmental allergies?	☐ **Yes**	☐ **No**
6.	Has the recipient ever tested positive for COVID-19 or been told they have COVID-19	☐ **Yes**	☐ **No**
7.	Has the recipient ever had a serious reaction after receiving a vaccine or injection?	☐ **Yes**	☐ **No**
8.	Has the recipient received monoclonal antibodies or convalescent serum for COVID-19 in the past 90 days?	☐ **Yes**	☐ **No**
9.	Has the recipient received any vaccine in the past 14 days?	☐ **Yes**	☐ **No**
10.	Does the recipient have a bleeding disorder or take a blood thinner?	☐ **Yes**	☐ **No**
11.	Does the recipient have a weakened immune system?	☐ **Yes**	☐ **No**
12.	For women only: Are you pregnant or breastfeeding a child?	☐ **Yes**	☐ **No**
13.	Does the recipient have a history of myocarditis or pericarditis?	☐ **Yes**	☐ **No**

If signing on behalf of a child under 19 years of age or a vulnerable adult, please fill out the following. If signing on your own behalf, simply sign and date the form.

I _____, have the legal authority to consent to medical treatment on behalf of the above named recipient. I confirm the following:

1. ***I have received and had the opportunity to read the Emergency Use Authorization Information Sheet (if applicable) for the above indicated COVID-19 vaccine. Any questions I have had about the vaccine have been answered to my satisfaction by a healthcare provider.***
2. ***The recipient has my consent to receive the _____ vaccine on _____ at _____.***
   (Pfizer, Moderna, or Janssen; Date; Time)
3. ***(If parent is not physically present) I consent to have the above listed COVID-19 vaccine administered to the recipient at date and location above without a parent or legal guardian present.***

_____ _____
SIGNATURE DATE