## South Heartland District Health Department - COVID-19 Vaccine Registration Form

Last Name	First Name	Date of Birth	Age	Doctor		
		31 2	8-	Yes	Don No kno	
Are you feeling sid	k today?					
•	eived a dose of COVID-19 vaccin cine product(s) did you receive ch  Moderna		Another Product			
How many dose	s of COVID-19 vaccine have you	ı received?	_			
Did you bring your vaccination record card or other documentation?						
or severely immu	alth condition or are you under nocompromised? (Thiswould induc grapy or high-dose corticosteroids, CART-o rome)	de treatment for cancer or HIV, rece	ipt of organ transplant,			
Have you received     CAR-T-cell therap	d COVID-19 vaccine before or dies?	uring hematopoietic cell t	ransplant (HCT) or			
(This would include a se to go to the hospital. It v • A component of a	d an allergic reaction to: everealleraic reaction [e.a anaphylaxis] the evould also include an allergic reaction that a COVID-19 vaccine, including either elycol (PEG), which is found in some erocedures	t caused hives, swelling, or respirate er of the following:	ory distress, including wheezing.)	_		
o Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids						
A previous dose of	of COVID-19 vaccine					
or an injectable m (This would include a se	d an allergic reaction to another nedication? evereallergic reaction [e.g., anaphylaxis] th vould also include an allergic reaction that	nat required treatment with epinep	hrine or EpiPen®or that caused yo	u		
7. Check all that app	ly to you:					
	myocarditis or pericarditis Multisystem Inflammatory Syndro	a m dram	istory of thrombosis with three (TTS)	ombocytopenia		
(MIS-C or MIS-A)	? ne-mediated syndrome defined by thrombocytopenia, such as hepari	Have a hi Have a hi	Have a history of Guillain-Barré Syndrome (GBS)  Have a history of COVID-19 disease within the past 3 months  Vaccinated with monkeypox vaccine in the last 4 weeks?			
	a copy of the Emergency Use Aut 8.31.22 □ Moderna Bivalen	·	e COVID-19 vaccine admin Pfizer (12+) 8.31.22 □			
Recipient Signature (	DR Parent/Legal Guardian for	recipient under age 19	Date			
Vaccinator's Signatu	re		Date			
E: Deltoid Rt Lt	DOSAGE: ROUT	TE: IM PLACESTICKI	ER HERE: Vaccine Lot Numl	oer and Expiratio	n Date	