

JANSSEN COVID-19 Vaccine Administration Record

Please Print Information about person to receive vaccine

Last name	First	Middle initial	Birth date	Age
Street address		City	Zip code	
Telephone #		Male <input type="checkbox"/>	Female <input type="checkbox"/>	Email Address:

I have read or have had explained to me the information in the Emergency Use Authorization (EUA) about the COVID-19 vaccine. I believe I understand the benefits and risks of the COVID-19 vaccine and ask that the COVID-19 vaccine be given to me or the person named above for who I am authorized to make this request. I authorize billing of the administration of vaccination to Medicare, Medicaid, or insurance.

I hereby acknowledge that I was offered a copy of the "Notice of Privacy Practices" from the Macon County Health Department dated 9/23/2013. _____ (initials)

CDC recommends waiting 15 minutes after receiving immunizations.

Signature of person to receive the COVID-19 vaccine, or the person authorized to make request:

X _____ Date: _____

Office use only

Booster

Manufactured by: Janssen

EUA given: _____

Site of vaccine: right left deltoid

Date Administered: / /

Lot #:

Clinic/office address: Macon Health Department, 1221 E Condit St, Decatur, IL 62521

Signature & Title of Vaccine Administrator _____

Medicare # _____

Medicaid # _____

Insurance:

Member ID/Group # _____

Screening Checklist for Contraindications to the JANSEEN COVID-19 Vaccination

For patients to be vaccinated: The following questions will help us determine if there is any reason we should not give you the JANSSEN vaccination today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the person to be vaccinated ever had a severe allergic reaction to any vaccine or injectable (intramuscular, intravenous, or subcutaneous) in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated been infected with COVID-19 in the last 90 days, received monoclonal antibodies or convalescent plasma as part of treatment in the last 90 days? (must be minimum 90 days since treatment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person to be vaccinated today previously received a COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form Completed by _____ Date _____

Form Reviewed by _____ Date _____

(www.immunize.org) Technical content reviewed by CDC