

Immunization Information System Data Requirement Form

COVID-19 Vaccine Administration



This form can be used in the rare instances when you are unable to access your jurisdiction's IIS due to technical issues or lack of internet access. When possible, information should always be captured electronically to avoid the least number of possible mistakes when transcribing.

However, this form may be printed to capture information manually. Vaccination providers are required to report vaccination administration information within 72 hours of administration. This information should be entered as soon you are able to access your jurisdiction's IIS or VAMS.

Recipient Information

ID _____

First Name _____

Middle Name (optional) _____

Last Name _____

Date of Birth _____

Sex Male Female Unknown

Insurance Information (Optional) _____

Insurer _____

Primary insurance holder _____

Group/Individual ID number _____

Address

Street 1 _____

Street 2 _____

City _____

Email _____

County _____

State _____

Zip Code _____

Cell Phone _____

Race *(select all that apply)*

<input type="checkbox"/>	American Indian/Alaskan Native	<input type="checkbox"/>	White
<input type="checkbox"/>	Asian	<input type="checkbox"/>	Other Race
<input type="checkbox"/>	Native Hawaiian or Pacific Islander	<input type="checkbox"/>	Unknown
<input type="checkbox"/>	Black/African American	<input type="checkbox"/>	Unable to report

Ethnicity *(select all that apply)*

<input type="checkbox"/>	Hispanic or Latino
<input type="checkbox"/>	Not Hispanic or Latino
<input type="checkbox"/>	Unknown
<input type="checkbox"/>	Unable to report

Vaccine Information

Type	Product	Date Administered	Manufacturer	Lot Number	Expiration Date <i>mmddyyyy</i>	# Wasted

Administration Site	Administration Route
LA (Left arm)	
RA (Left arm)	C28161 (Intramuscular)
LE (lower extremity) Left Right	

Dose Number		Missed Appointment	Y/N	Comorbidity	Y/N
--------------------	--	---------------------------	-----	--------------------	-----

Refused Vaccination	Y/N	If Yes, Reason	
----------------------------	-----	-----------------------	--

Vaccinator		Received EUA Fact Sheet for Recipients	Y/N
-------------------	--	---	-----

Prevaccination Checklist for COVID-19 Vaccines



For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever received a dose of COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> If yes, which vaccine product did you receive? <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another Product _____ Have you received a complete COVID-19 vaccine series (i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna])? Did you bring your vaccination record card or other documentation? 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had an allergic reaction to:			
<i>(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)</i>			
<ul style="list-style-type: none"> A component of a COVID-19 vaccine, including either of the following: <ul style="list-style-type: none"> Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids A previous dose of COVID-19 vaccine 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)</i>			
5. Check all that apply to you:			
<input type="checkbox"/> Am a female between ages 18 and 49 years old			
<input type="checkbox"/> Am a male between ages 12 and 29 years old			
<input type="checkbox"/> Have a history of myocarditis or pericarditis			
<input type="checkbox"/> Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies			
<input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum			
<input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection			
<input type="checkbox"/> Have a bleeding disorder			
<input type="checkbox"/> Take a blood thinner			
<input type="checkbox"/> Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies			
<input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT)			
<input type="checkbox"/> Am currently pregnant or breastfeeding			
<input type="checkbox"/> Have received dermal fillers			
<input type="checkbox"/> History of Guillain-Barré Syndrome (GBS)			

Form reviewed by _____

Date _____