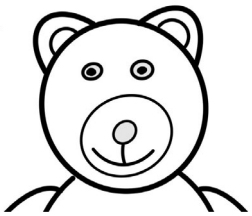
Health Department

CHILD VACCINATION ADMINISTRATION RECORD

COVID-19 Vaccine

Clients 6 months through 11 years old



SECTION 1a CLIENT INFORMATION *(Please PRINT clearly)*

Today's Date: _____

Child's Legal Name:

_____ _____ _____
Last Name *First Name* *Middle Name*

Date of Birth: _____ **Other Names Used Since Birth:** _____
MM/DD/YYYY *(Previous Name, etc.):*

Gender: ☐ Male ☐ Female

Race: ☐ White ☐ Asian ☐ Native Alaskan/American Indian
☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Multi-Racial (Select all that apply)

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

SECTION 1b PARENT/RESPONSIBLE PARTY INFORMATION

Responsible Party Last Name: _____ **Responsible Party First Name:** _____

Relationship: ☐ Parent ☐ Legal Guardian ☐ Power of Attorney

Address: _____
Street Address

_____ _____ _____
City *State* *Zip Code*

Phone Number: _____
(Area Code) Phone Number

SECTION 2 MEDICAL SCREENING QUESTIONNAIRE

1. Is the child currently ill or running a fever?	☐ Yes	☐ No
2. Has the child received any vaccine within the past 14 days?	☐ Yes	☐ No
3. Has the child ever had a severe allergic reaction to any of the following items? ▪ A previous dose of COVID-19 vaccine or any other vaccine ▪ Medication or therapy, polyethylene glycol (PEG) or polysorbate ▪ Food item, pet, insect, latex, environmental substance or any other substance	☐ Yes	☐ No
4. Does the child have a low platelet count or a bleeding disorder?	☐ Yes	☐ No
5. Has the child previously been treated for COVID-19 with monoclonal antibodies or convalescent plasma?	☐ Yes	☐ No

SECTION 3 CONSENT

A	**CONSENT FOR SERVICES:** I have read or have had explained to me, the information contained in the Emergency Use Authorization Fact Sheet regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s). I ask that the vaccine(s) be given to me, or to the person for whom I am authorized to make this request. I also authorize the Macomb County Health Department to release my immunization record information, or the immunization record information of the person for whom I am authorized to make this request to other health care provider(s) as needed and to other public health authorities (e.g. for entry into an immunization registry for Covid-19 Vaccine reporting requirements).
B	**NOTICE OF PRIVACY PRACTICES:** I have received notification of the Macomb County Health Department's Notice of Health Information Practices. I understand that my acknowledgement of the Notice is evidenced by my signature on this document. The Department is required to abide by the terms of this privacy notice. The Department may change the terms of its notice at any time. The new notice will be effective for all protected health information that it maintains at that time. Upon my request, the Department will provide me with the revised notice of privacy practices.

By signing below, I hereby acknowledge that I have read and fully understand the applicable statements on this form.

SIGNATURE of Parent/Responsible Party _____ Date _____

PRINT NAME of Parent/Responsible Party _____

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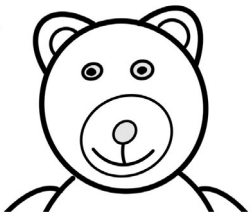

Office Use Only

SECTION 4	**Registration Information**			
Service Location	☐ 91 – MC Outreach ☐ 92 – SW Outreach ☐ 93 – SE Outreach	☐ Mount Clemens (01) ☐ Southwest (02) ☐ Southeast (03)	**Entered in MCIR by**	
			Date Entered in MCIR	

SECTION 5	**Vaccine Documentation**
Vaccination Checklist	☐ Birthdate Confirmed ☐ Screening Questions Reviewed ☐ EUA Fact Sheet Given ☐ Provided COVID-19 Vaccination Record

Vaccine	MFR	Lot Number/Dose/Volume	Site		Route
Pfizer (Maroon Cap)					
COVID-19 Vaccine mRNA, LNP-S, PF, tri-sucrose	☐ Pfizer-BNT 6 months through 4 years old	***LOT #*** ☐ Dose 1 **(3 mcg/0.2 mL dose)** ☐ Dose 2 **(3 mcg/0.2 mL dose)** ☐ Dose 3 **(3 mcg/0.2 mL dose)**	☐ Right Arm (Deltoid) ☐ Left Arm (Deltoid)	☐ Right Thigh ☐ Left Thigh	IM
Pfizer (Orange Cap)					
COVID-19 Vaccine mRNA, LNP-S, PF, tri-sucrose	☐ Pfizer-BNT 5 years through 11 years old	***LOT #*** ☐ Dose 1 **(10 mcg/0.2 mL dose)** ☐ Dose 2 **(10 mcg/0.2 mL dose)** ☐ Dose 3 **(10 mcg/0.2 mL dose)*** ☐ ****Booster #1*** **(10 mcg/0.2 mL dose)**	☐ Right Arm (Deltoid) ☐ Left Arm (Deltoid)	☐ Right Thigh ☐ Left Thigh	IM
Moderna (Blue/Magenta Label)					
COVID-19, mRNA, LNP-S, PF, pediatric	☐ Moderna 6 months through 5 years old	***LOT #*** ☐ Dose 1 **(25 mcg/0.25 mL dose)** ☐ Dose 2 **(25 mcg/0.25 mL dose)** ☐ Dose 3 **(25 mcg/0.25 mL dose)***	☐ Right Arm (Deltoid) ☐ Left Arm (Deltoid)	☐ Right Thigh ☐ Left Thigh	IM
Moderna (Teal/Purple Label)					
COVID-19, mRNA, LNP-S, PF	☐ Moderna 6 years through 11 years old	***LOT #*** ☐ Dose 1 **(50 mcg/0.5 mL dose)** ☐ Dose 2 **(50 mcg/0.5 mL dose)** ☐ Dose 3 **(50 mcg/0.5 mL dose)***	☐ Right Arm (Deltoid) ☐ Left Arm (Deltoid)	☐ Right Thigh ☐ Left Thigh	IM

** Dose #3 administered when client requires an Additional Dose due to an immunocompromised condition.*

Staff Administering Vaccine	
Date	

PROGRESS NOTES