Kalamazoo County Health & Community Services – COVID-19 Vaccine Registration

Full Name:_____ Maiden Name:_____

Date of Birth: _____ **Age:** _____ **Legal Sex:** ◯Male ◯Female

Ethnicity: ☐ Hispanic or Latino/a ☐ Not Hispanic or Latino/a ☐ Declined

Race: ☐African American or Black ☐American Indian ☐Alaskan Native ☐Asian ☐White Other _____

Address: _____ **Phone Number:** _____

City: _____ **State:** _____ **Zip Code:** _____ **County of Residence:** _____

Employer: _____ **Email Address:** _____

Emergency Contact: _____ **Phone Number:** _____

1. Do you feel sick today? ☐ Yes ☐ No
2. Have you ever received a dose of COVID-19 vaccine? ☐ Yes ☐ No
   If yes, which product did you receive?
   ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson (Janssen) ☐ Another Product: _____
3. Have you ever had an allergic reaction to a component of the COVID-19 vaccine, such as polyethelene glycol (PEG), polysorbate, or a previous dose of COVID-19 vaccine? ☐ Yes ☐ No
4. Have you ever had an allergic reaction to any injectable medication or vaccine? This includes rash, problems breathing, swelling, use of epinephrine or a hospital visit. ☐ Yes ☐ No
5. Have you ever had a severe allergic reaction to medications, foods, pets, or a substance that resulted in problems breathing, swelling, use of epinephrine or a hospital visit? ☐ Yes ☐ No
6. Have you ever fainted after getting a shot or blood draw? ☐ Yes ☐ No
7. Do you have a weakened immune system due to HIV/AIDS, cancer, or any other condition or are you taking immunosuppressive treatments like steroids, anticancer drugs or radiation? ☐ Yes ☐ No
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? Note: this is different than COVID-19 vaccination. ☐ Yes ☐ No
9. Are you pregnant or breastfeeding? ☐ Yes ☐ No
10. Have you had any other vaccinations in the last 14 days?
    If so, what? _____ ☐ Yes ☐ No
11. Do you have a bleeding disorder or are you taking a blood thinner? ☐ Yes ☐ No
12. Have you ever had COVID-19 or a positive COVID-19 test? ☐ Yes ☐ No
13. Do you have dermal fillers (for example, skin injections for wrinkles)? ☐ Yes ☐ No

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HCS Clinical Review:

Reviewed by HCS Team Member – Initials: _____ **Date:** _____

If vaccination deferred, rationale: _____

Observation (check):

☐ **15 minutes**

☐ **30 minutes**

REGISTRATION ACKNOWLEDGEMENT

I certify that information I provide to Kalamazoo County Health and Community Services (HCS) is true and accurate. I authorize the release of pertinent medical information to my health insurance carrier(s) to the extent permitted by Law. I authorize HCS to administer the COVID-19 vaccination. I am aware that I must remain at the clinical site for fifteen to thirty minutes, depending on my past medical history, following the vaccine for observation of a possible reaction. I waive and release HCS, and its authorized agents, for any and all liability arising, directly or indirectly, out of HCS's administration of the COVID-19 vaccine, my receiving the COVID-19 vaccine, any to reaction to vaccine, or injury sustained while at any clinic run by Kalamazoo County staff and its agents. HCS makes no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness for a particular purpose regarding the COVID-19 vaccine or its effectiveness. I understand vaccination documentation is required to occur in the Michigan Care Improvement Registry (MCIR) where I can request through my medical provider access to my immunization record. For best protection against COVID-19, I understand it is strongly recommended to complete two doses of vaccination in the recommended timeframe.

ACKNOWLEDGEMENT OF RECEIPT FORM-NOTICE OF PRIVACY PRACTICES

I, hereby acknowledge the receipt **of Notice of Privacy Practices** from Kalamazoo County Health and Community Services Department (HCS).

Authorization Form – Use or Disclosure of Protected Health Information (PHI)

I understand that signing this authorization is voluntary and that if I refuse to sign this form it will not prevent receipt of health care or eligibility for benefits under a health plan. I understand that I am entitled to receive a copy of this form upon signing it. I understand that if the organization or individual authorized to receive the information is not a health care provider; the released information may no longer be protected by federal privacy regulations. I understand that I have the right to revoke this authorization, that the revocation applies to uses and disclosures made after the revocation is made.

I understand the risks and benefits associated with the above vaccine I have elected to receive and acknowledge that I have received and reviewed the written disclosures of the possible risks and benefits of the COVID-19 vaccine provided by vaccine manufacturers and regarding vaccines from the Centers for Disease Control and Prevention and the Food and Drug Administration.

Signature_____ Date_____

Legal Guardian_____ Date_____

Below to be completed by Clinic Staff

Date of Service:_____ **Clinical Staff Initials:_____**

Vaccine	Lot Number	Site
COVID Vaccine Product Name:_____		☐ **RA** ☐ **LA** ☐ **RT** ☐ **LT**