Hennepin Healthcare

COVID-19 Vaccine
Registration Form

Clinic # _____

PRINT IN INK ONLY. REQUIRED INFO FOR PATIENT RECEIVING VACCINE.

Last name

First name

Middle name **SSN - last 4 digits**

Sex **Date of birth (MM/DD/YYYY)** **Age**

Address

City

State **Zip**

Phone ☐ **Home or** ☐ **Cell**

If patient is under 18

PARENT/LEGAL GUARDIAN FULL NAME

PARENT/LEGAL GUARDIAN DOB (MM/DD/YY) SEX

***OPTIONAL* DEMOGRAPHIC INFORMATION**
Check all that apply. Race

- ☐ American Indian (Native American) or Alaskan Native
- ☐ Asian
- ☐ Black (African American or African)
- ☐ Hispanic (Latino)
- ☐ Native Hawaiian or Pacific Islander
- ☐ Prefer not to answer
- ☐ White (Caucasian, Non-Hispanic)

***OPTIONAL* DEMOGRAPHIC INFORMATION.**

Preferred language

- ☐ English
- ☐ Hmong
- ☐ Spanish
- ☐ Somali

Ethnic background

- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino

☐ Other _____

INSURANCE INFORMATION
Regardless of insurance coverage status, patients will NOT be billed for vaccinations

☐ **No insurance**

(#1) Primary insurance company name

Insurance ID#

Group #

(#2) Secondary insurance company name

Insurance ID#

Group #

POLICY HOLDER INFORMATION

☐ **Self (skip section below)** ☐ **Spouse**
☐ **Parent** ☐ **Other**

Policy holder last name

Policy holder first name

Policy holder date of birth (MM/DD/YYYY)

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ABSOLUTE CONTRAINDICATION TO VACCINATION If participant answers 'Yes' to any questions 1-3, **DO NOT VACCINATE**, refer to allergist for 'Yes' to 1-2.	**Y**	**N**
1. Have you had a severe reaction to any component of the vaccine? (RN will have an ingredient list available to review at time of vaccination.)		
2. Have you had an immediate allergic reaction within 15-30 minutes of any severity to a previous dose of an mRNA COVID-19 vaccine or any of its components? • Skin: Pruritus, hives, flushing, angioedema • Neurologic: Confusion, disorientation, dizziness, lightheadedness, weakness, loss of consciousness • Respiratory: Shortness of breath, wheezing, bronchospasm, stridor, hypoxia • Cardiovascular: Hypotension, tachycardia • Gastrointestinal: Nausea, vomiting, abdominal cramps, diarrhea		
3. Have you already received a different COVID-19 vaccine product?		

TEMPORARY CONTRAINDICATIONS OR PRECAUTIONS TO VACCINATION If participant answers 'Yes' to any questions 1-5, delay vaccination for time frame listed under question. If participant answers 'Yes' to question 6, *do symptom risk assessment and counseling.* If participant answers 'Yes' to question 7, *do allergy risk assessment and counseling.*	**Y**	**N**
1. Were you recently diagnosed with COVID-19 and still in your isolation period? *(Delay vaccination until past acute infection and out of isolation)*		
2. Have you had a high-risk exposure to COVID-19 in the past 14 days? *(You are able to be vaccinated but if you develop any post-vaccination symptoms that could also be COVID-19, you must leave work and be tested immediately.)*		
3. Have you had a diagnosis of COVID-19 in the past 90 days? *(If so, you can get the vaccine at any time but you likely have some antibodies and thought to be low risk for reinfection for 90 days so you may consider delaying it if resources are scarce to allow others who haven't had disease yet get vaccinated first.)*		
4. Have you received either convalescent plasma or a monoclonal antibody therapy (e.g. Bamlanivimab or Casirivimab/Imdevimab) in the past 90 days for treatment of COVID-19? *(Delay vaccination for 90 days after infusion)*		
5. Have you had any other vaccines in the past 14 days or do you plan to in the next 14 days? *(Delay vaccination so no other vaccines are given within 14 days of the COVID-19 vaccine on either end)*		
6. Are you currently ill with a fever or moderate/severe illness? *(If so, needs symptom risk assessment.)*		
7. Have you ever had a history of a severe allergic reaction (e.g., anaphylaxis) to any other vaccine or injectable therapy (e.g., intramuscular, intravenous, or subcutaneous)? *(If so, a risk assessment needs to be done first before vaccination. If appropriate to vaccinate, precautions should be taken while receiving the vaccine.)*		

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MAY PROCEED WITH VACCINATION		Y	N
If participant answers 'Yes' to questions 1-3, ok to proceed with vaccination, but they may want to discuss with their provider first.	Observation period post-vaccination: 15 minutes Observation site: standard vaccination location		
If participate answers 'Yes' to questions 4-8, ok to proceed with vaccination.	Observation period post-vaccination: 30 minutes: Persons with a history of severe allergic reaction (e.g., anaphylaxis) due to any cause 15 minutes: Persons with allergic reaction, but not anaphylaxis Observation site: standard vaccination location		
1. Are you pregnant?			
2. Are you breastfeeding?			
3. Do you have any immunocompromising conditions or are you on medications that suppress your immune system?			
4. Do you have a history of food, pet, insect, venom, environmental, latex, or other allergies not related to vaccines or injectable therapies?			
5. Do you have a history of allergy to oral medications (including the oral equivalent of an injectable medication)?			
6. Do you have a non-serious allergy to vaccines or other injectables (e.g., no anaphylaxis)?			
7. Do you have a family history of anaphylaxis?			
8. Do you have any other history of anaphylaxis that is not related to a vaccine or injectable therapy?			

I had an opportunity to review the EUA Vaccine Fact Sheet today and ask questions and received answers to my satisfaction. I understand the benefits and risks of the vaccination and expressly authorize a nurse to administer the vaccine to me. I hereby release Hennepin Health Systems (HHS) dba MVNA, its officers, employees, agents; from any and all liability that might arise from vaccination on behalf of me, my heirs and personal representatives. I acknowledge that a copy of HHS Notice of Privacy Practices is available to me, which provides an explanation of the way in which my health information may be used or disclosed by HHS and of my rights with respect to my health information.

Signature_____ Date _____

Parent/Legal Guardian signature required, if patient under 18 years old

NURSE ONLY

Manufacturer	Dose	Age	Site	Dose 1 or 2	Lot number (sticker)	Expiration date
Pfizer	☐ 0.3 mL	☐ 16 yrs +	IM Deltoid: **L** or **R**	☐ 1 ☐ 2	Diluent Lot #	Exp date
Moderna	☐ 0.5 mL	☐ 18 yrs +	IM Deltoid: **L** or **R**	☐ 1 ☐ 2		
Janssen	☐ 0.5 mL	☐ 18 yrs +	IM Deltoid: **L** or **R**	☐ 1		

Vaccine administrator signature _____

RN name (please print)_____ Date____/____/____

EUA Vaccine Fact Sheet given/offered today: ☐ (RN to check box) Administration complete in Epic? ☐