COVID-19 Vaccination Patient Record **12 years and older**

For Documentation in Vaccine Administration Management System (VAMS)

This document facilitates capture of data required for documentation in VAMS

Section I: PATIENT or PATIENT REPRESENTATIVE to complete this section

Today's Date	**First Name** (Print)*	**Last Name** (Print)*	**Gender** (select one)* ☐ Female ☐ Decline to Specify ☐ Male ☐ Other

Date of Birth*	**Race***	**Address**
Ethnicity* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Not Reported	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Unknown/Not Reported	**County of Residence**
Tribe of Membership		**Phone**

COVID Vaccine dose:	**If 2nd/3rd/booster dose, enter date and facility of previous dose(s):**
☐ 1st dose ☐ 2nd dose ☐ 3rd dose ☐ Booster	

Section II: To Be Completed By HEALTHCARE PROFESSIONAL Administering Vaccine

Date COVID-19 vaccine administered:	**Facility/Location:**

COVID-19 Vaccine Prevaccination Checklist reviewed and vaccination administration deemed appropriate:
☐ Yes ☐ No ☐ Precaution identified and vaccination in an alternate setting needed

☐ **Moderna** (Red Cap) ☐ 1st dose 100mcg/**0.5mL** ☐ 3rd dose (Immunocompromised) 100mcg/**0.5mL**
12 yrs and older ☐ 2nd dose 100mcg/**0.5mL**

☐ **Moderna Booster 50mcg/0.5mL** ☐ Bivalent Booster dose 50mcg/**0.5mL**
18 yrs and older (Blue Cap)

☐ **Pfizer** ☐ 1st dose 30mcg/**0.3mL** ☐ 3rd dose (Immunocompromised) 30mcg/**0.3mL**
12 yrs and older ☐ 2nd dose 30mcg/**0.3mL** ☐ Bivalent Booster dose 30mcg/**0.3mL**
(Gray, Purple Cap)

☐ **Janssen: 18 years and older** ☐ 1st dose **0.5 mL** ☐ Booster **0.5 mL**

☐ **Novavax: 12 years and older** ☐ 1st dose **0.5 mL** ☐ 2nd dose **0.5 mL**

Lot Number:	**Expiration:**	**Administration time:**	**Date of Vaccine Information Statement (VIS) or Emergency Use Authorization (EUA) Fact Sheet:**

Immunization site: ☐ Right Deltoid ☐ Left Deltoid

Was today's vaccination administration successful? ☐ Yes ☐ No
If no, is it possible to reattempt administration? ☐ Yes ☐ No
(this is a default question in VAMS and is likely not applicable to most IHS/Tribal/Urban organizations that are utilizing VAMS)

If vaccination was unsuccessful select reason:
☐ Sick or fever ☐ Inventory Shortage
☐ No longer interested ☐ Other:
☐ Staffing ☐ Contraindication identified
☐ _____

Was any vaccine wasted during administration?
☐ Yes ☐ No
If vaccine wasted select reason:
☐ Broken Vial/Syringe
☐ Vaccine drawn but not administered
☐ Non-vaccine product (e.g. IG, HBIG, Dil)
☐ Open vial but all doses not administered
☐ Lost or unaccounted for vaccine
☐ Other:

☐ COVID vaccination documentation completed in VAMS
☐ COVID vaccination documentation completed in Patient Medical Record

_____ _____

Signature and Title of Vaccinator **Date**

Prevaccination Checklist for COVID-19 Vaccination

Name _____

For vaccine recipients (both children and adults):

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

	Yes	No	Don't know
1. How old is the person to be vaccinated? _____			
2. Is the person to be vaccinated sick today?	☐	☐	☐
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product was administered? ☐ Pfizer-BioNTech ☐ Janssen *(Johnson & Johnson)* ☐ Another Product ☐ Moderna ☐ Novavax _____			
• How many doses of COVID-19 vaccine were administered? _____			
• Did you bring the vaccination record card or other documentation?	☐	☐	
4. Is the person to be vaccinated have a health condition or undergoing treatment that makes them moderately or severely immunocompromised? *This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.*	☐	☐	☐
5. Is the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. Has the person to be vaccinated ever had an allergic reaction to: *(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.)*			
• A component of a COVID-19 vaccine	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. Has the person to be vaccinated ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? *(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.)*	☐	☐	☐

8. Check all that apply to the person to be vaccinated:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months?

Form reviewed by _____ **Date** _____

POARCH BAND OF CREEK INDIANS HEALTH DEPARTMENT COVID-19 VACCINATION CONSENT FORM

PATIENT NAME: _____DOB:_____ M OR F_____

STREET ADDRESS: _____ CITY: _____ STATE: _____

ZIPCODE: _____

HOME PHONE NUMBER: _____

NAME OF PRIMARY CARE PHYSICIAN: _____

ADDRESS OF PRIMARY CARE PHYSICIAN: _____

TELEPHONE NUMBER OF PRIMARY CARE PHYSICIAN: _____

I authorize an authorized healthcare provider of the Poarch Band of Creek Indians Health Department to administer the Moderna COVID-19 Vaccine to me. I further understand, agree, certify, and authorize the following:

1. The patient named above is a Tribal Member, first generation descendent, a member of a Tribal Member household, a Tribal employee, and/or a member of the Poarch Band of Creek Indians' community, and is a resident of _____.
2. I have been informed of the potential side effects and reactions that may occur with this vaccine.
3. I understand that I must have a second dose of the vaccine one month following my initial dose.
4. I authorize the Poarch Band of Creek Indians Health Department to release information regarding the vaccine, including my identity and any reactions to the necessary state, federal, local or tribal officials.

By signing below, I acknowledge that I have read, understand, agree, certify, and/or authorize the consent and information above and further agree to hold harmless the Poarch Band of Creek Indians Health Department and the Poarch Band of Creek Indians including its employees, agents, and contractors from any and all liability and claims.

_____

Patient Signature Date

_____

Parent or Guardian Signature (All patients under 18) Date

_____

Witness Date