Iredell County Health Department
Formulario de Inscripción para la Vacuna del COVID-19

Dosis que se está administrando: □ 1ra □ 2da □ 3ra/Refuerzo- #_____

Recipiente de la Vacuna o Personal de Registración llene **la primera sección (favor imprimir)**

Nombre: _____ _____
Primer Apellido

Fecha de Nacimiento: _____ Edad: _____ Sexo: □ Masculino □ Femenino □ Otro: _____

Dirección: _____ Ciudad: _____

Estado: _____ Código Postal: _____Condado: _____Teléfono: _____

Correo Electrónico: _____ Método de contacto preferido: □ Texto □ CE □ Ambos □ Ninguno

Raza: □ Negro o Afroamericano □ Blanco □ Asiático □ Otro: _____ Etnicidad: Hispano/Latino- □ Sí □ No

Idioma hablado: □ Inglés □ Español □ Otro: _____Social Security #: _____
Alergias a un medicamento? □ Sí □ No- Si es sí dígalos: _____

Complete si está recibiendo la 2da 3ra dosis o <u>dosis de refuerzo</u>:

Dosis anterior(es) administrada(s) por: □ el Departamento de Salud □ Otro Proveedor

Nombre de la Vacuna recibida en la dosis anterior(es): □ Pfizer □ Moderna □ Johnson & Johnson
□ Inseguro de cual Vacuna le dieron en la dosis anterior(es) □ Otro: _____

□ Fecha de 1ra dosis ____/____/____ □Conocido □Aproximado
(requerido) mes / día / año

□Fecha de 2da dosis____/____/____ □Conocido □Aproximado
(requerido) mes / día / año

□Recibir el 2da, 3ra o dosis de Refuerzo: Testifico que ha pasado el tiempo recomendado desde la dosis anterior- 2da dosis-21 días; 3ra dosis-28 días; Dosis de Refuerzo- 6 meses: _____
Firma

□Recibir la 3ra dosis- Testifico que tengo el sistema inmunitario comprometido: _____
Firma

Si usted tiene seguro médico, por favor darnos su información. A usted no se le cobrará ningún costo si su seguro médico no cubre.

Compañía de Seguro: _____ Número de Póliza: _____

Número de Grupo: _____ Suscriptor: _____

□ Aviso de Privacidad dado

<u>Consentimiento por Escrito del Padre/Tutor (requerido para la vacunación de menores de 18 años de edad):</u>

X_____ **Fecha:** _____

Búscanos en Facebook

Relación con la paciente: ☐ Padre ☐ Tutor Legal

Updated 10/6/21

Vaccinator complete **section 2:**

Females:

Pregnant? □ Yes □ No- □ **If yes,** explained that there are no data on the safety of COVID-19 vaccine in pregnant women. Should discuss with physician prior to vaccination if questions or concerns.

Breastfeeding? □ Yes □ No- □ **If yes**, explained that that there are no data on the safety of COVID-19 vaccine in breastfeeding women or on the effects on the breastfed infant or milk production/excretion. Should discuss with physician prior to vaccination if questions or concerns.

Females 18 through 49 years of age: if giving Janssen brand of vaccine, notify of the rare but increased risk of thrombosis with thrombocytopenia syndrome (TTS) after vaccination.

Males 12 through 29 years of age: inform of risk of developing myocarditis or pericarditis after receipt of mRNA vaccine (Moderna or Pfizer)

All recipients:

□ The following handouts were given and were reviewed by the individual/caregiver prior to vaccination:

- COVID-19 Vaccine Pre-Vaccination Screening
- Fact Sheet for Recipients and Caregivers Emergency Use Authorization (EUA) for COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19)
- V-safe after vaccination health checker information

□ Screened for potential allergy to vaccine or components of the vaccine.

□ If individual has a bleeding disorder or takes a blood thinner explain the increased risk for bleeding after IM vaccination. Contact physician is bleeding occurs that can't be stopped.

□ Encouraged to remain in observation area for 15 minutes; 30 minutes if history of an anaphylactic reaction to any vaccine or other injectable therapy.

□ Instructed to contact a healthcare provider immediately if symptoms of allergic reaction occur, including shortness of breath, hoarseness, wheezing, hives, paleness, weakness, elevated heart rate, or severe dizziness.

□ Instructed to call and report any severe adverse reactions after receiving the vaccine

□ **Verbal consent:** The benefits of vaccination and potential adverse reactions, including severe allergic reaction, have been explained to the individual/caregiver and they have provided verbal consent to have the vaccine administered. Nurse initials: _____

Administered by: _____ Title: _____

Date: _____ Time: _____ Site: RD_____ LD_____ RVL_____ LVL _____

□ If first dose of Moderna vaccine, instructed to return for 2nd dose in *28 days

□ If first dose of Pfizer vaccine, instructed to return for 2nd dose in *21 days

Affix Label Here with
vaccine name and manufacturer,
Lot # and Expiration Date

Complete if 3rd/booster dose:

□ Current criteria met to receive booster dose 28 days after previous dose due to immune compromised condition

□ Current criteria met to receive a booster dose 6 months after previous dose

***Note: If receiving the first in a 2-dose series, the second dose should be given as close as possible to the target date, but if target date is missed there is no need to restart or repeat any doses. Not to be given earlier than day 24 after the first vaccine Moderna or day 17 after the first Pfizer vaccine.**