COVID-19 Vaccination Administration Form

SECTION I: To be completed by Client or Parent/Legal Guardian (if client less than 16 years of age).

DEMOGRAPHICS

Name:	**Date of Birth:**	**Age:**
Street Address:	**Email address:**	
City/State:	**Zip Code:**	**County:**
Telephone: ☐ cell ☐ home	**Race:**	**Sex:**
Preferred Method of Contact: ☐ Call ☐ Mail	**Preferred Phone/Address (if different from above)**	
Emergency Contact:	**Emergency Phone:**	

SCREENING

The following questions apply to the person being vaccinated:	Yes	No
1. Are you feeling sick today?		
2. Have you received a previous dose of COVID-19 vaccine? If yes, when_____which manufacturer?		
3. Have you had a severe allergic reaction (e.g. anaphylaxis) to something? For example, a reaction for which you were treated with a epinephrine or Epi-pen, or for which you had to go to the hospital?		
4. Have you had any other vaccinations in the previous 14 days?		
5. Have you had a positive test for COVID-19 or has your doctor ever told you that you had COVID-19?		
6. Have you received passive antibody therapy (monoclonal antibodies or convalescent plasma) as treatment for COVID-19?		
7. In the past 2 weeks, have you tested positive for COVID-19?		
8. Do you have allergies or reactions to any medications, foods, vaccines, or latex? If yes, please explain		
9. Do you have a weakened immune system cause by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
10. Do you have a bleeding disorder or are you taking a blood thinner?		
11. For women, are you pregnant or breastfeeding?		

I have completed SECTION 1. By my signature below as client, parent, legal guardian, or other responsible party, I hereby give my consent to and authorize South Carolina Department of Health and Environmental Control employees and agents to provide immunization services and medical care to me or, in case of a parent or legal guardian, to my child or ward.

Client/Parent/Legal Guardian Signature (if client less than 16 years of age):_____

Relationship to Client:_____   **Date:**_____

SECTION II: To be completed by DHEC staff.

DOCUMENTATION

Vaccine Name	Dosage	Dose #	Site	Route	Manufacturer	Lot #	EUA Fact Sheet
Moderna COVID-19 Vaccine	0.5ml	☐ 1 ☐ 2	☐ LA ☐ RA ☐ LL ☐ RL	IM	Moderna		☐ Fact sheet provided
Pfizer- BioNTech COVID-19 Vaccine	0.3ml	☐ 1 ☐ 2	☐ LA ☐ RA ☐ LL ☐ RL	IM	Pfizer		☐ Fact sheet provided
Janssen COVID-19 Vaccine	0.5ml	☐ 1	☐ LA ☐ RA ☐ LL ☐ RL	IM	Janssen		☐ Fact sheet provided

Signature/Title of Person Administering Vaccine:	**Date/Time:**
Clinic Site or Health Department:	VAMS Entry Complete: ☐

COVID-19 Vaccination Form
INSTRUCTIONS FOR COMPLETING

Purpose

To provide demographic information, COVID-19 vaccine history, screening, and immunization documentation for administered COVID-19 vaccine in the event of the inability to access the Vaccine Administration Management System (VAMS).

SECTION I: To be completed by Client or Parent/ Legal Guardian (if client is less than 16 years of age)

Demographics

- Complete boxes with appropriate information.
- DHEC staff to record assigned MCI number.

Screening.

- Complete screening questions.

Signature

- Sign and date form and indicate relationship to client (if applicable).

SECTION II: To be completed by DHEC staff

Documentation

- Complete the dosage, dose number, site, and lot number for the vaccine administered.
- Check the appropriate box in cells where check boxes are available.

Signature and Site (DHEC staff)

- Sign (including title), date, and time the form.
- Record the clinic site/ health department

IIS Entry

- Enter administered vaccine or immune globulin into the VAMS system and check the box to confirm entry.

Office Mechanics

- Forms should be batch filed by year and applicable health record retention schedule (8498 - Adult Comprehensive Health Record and 8499 - Minor Comprehensive Health Record). Records must be maintained in the health department's medical records room or other designated secure area.