|  |  |  |
| --- | --- | --- |
| Program | **Prince George’s County Health Department** | Date |
| **Immunizations** |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |
| Month |  | Day |  | Year |

 |
| Location | **FLU/COVID-19 VACCINE ADMINISTRATION RECORD****Please Print** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Name** (Last) | (First) | (M.I) | **Medical Record Number** (**Office Use Only)** |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Street Address** | **Apartment Number** | **Date of Birth** |
|  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |
| Month |  | Day |  | Year |

 |
| City | State | Age (Office Use Only) | Sex (Circle One) |
|  |  |  | Male | Female |
| **Zip Code Are you a Health Department Employee?** | **Are you Hispanic or Latino?** ☐ Yes ☐ No |
|

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |

 |  | **YES** | **NO** | **Race** | Select one of the following racesIf you are multiracial, check all that apply: |
|  |
| ☐ American Indian☐ Asian | ☐ White☐ Other: \_\_\_\_\_\_\_\_\_ |
| **Phone Number** | **Email** |
|

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | - |  |  |  | - |  |  |  |  |

 |  | ☐ Black/ African American☐ Native Hawaiian/ Pacific Islander |
| **Parent/ Legal Guardian/ Custodian** | **Mother’s Maiden name** | **Relationship to Client** |
|  | **CIRCLE****ONE** | **COMMENTS** |
| 1. Are you or the person being vaccinated sick today?
 | YES | NO |  |
| 1. Do you or the person being vaccinated have a fever today?
 | YES | NO |  |
| 1. Are you or the person being vaccinated allergic or sensitive to latex?
 | YES | NO |  |
| 1. Are you or the person being vaccinated pregnant?
 | YES | NO |  |
| 1. Is this the first FLU or COVID-19 vaccination received?
 | YES | NO |  |
| 1. Is the recipient breastfeeding?
 | YES | NO |  |
| 7. Have you or the person being vaccinated ever had a severe allergic reaction (e.g., anaphylaxis)  after receiving **Flu or COVID-19** vaccine.  | YES | NO |  |
| 8. **FOR FLU ONLY**a. Are you allergic to egg or egg products? Explainb. Are you allergic to any medication or thimerosal?c. Have you or the person being vaccinated ever have Guillain-Barre Syndrome? Explain | YESYES YES | NONONO |  |
|  9. **FOR COVID ONLY** a. Do you or the person being vaccinated test positive for COVID-19 in the past few days? b. Do you or the person being vaccinated have a bleeding disorder or taking blood thinners?  | YES | NO |  |
|  |  |  |  |  |  |
|  c. Have you or the person being vaccinated received passive antibody therapy (monoclonal  antibodies or convalescent serum) as treatment for COVID-19 in the past 90 days? | YES | NO |  |
| **Recipient Signature/ Parent or Guardian**  | **Date:** |

**This person qualifies for vaccinations through the Maryland VFC (Vaccines) Program because he/she:**

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**(Please check one of the following boxes):**

**☐ a. Is covered by or enrolled in Medical Assistance (****United Healthcare, Priority Partners, Amerigroup, etc.) OR**

**☐ b. Does not have health insurance, OR**

**☐ c. Is Native American (American Indian) or Alaskan Native, OR**

**☐ d. Has health insurance that does not cover (pay for) vaccines.**

**FOR NURSES ONLY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Vaccine Manufacturer** | **Vaccine Lot Number**  | **Expiration Date** | **Injection Site** | **Date Administered** | **Vaccine Administrator Signature** |
| **INFLUENZA** |  |  |  |  |  |
| **Vaccine Manufacturer** | **Vaccine Lot Number**  | **Expiration Date** | **Injection Site** | **Date Administered** | **Vaccine Administrator Signature** |
| **COVID-19** |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Nurse Signature & Date**  |  | **Comments:** |