|  |  |  |
| --- | --- | --- |
| 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 races  If 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? Explain  b. Are you allergic to any medication or thimerosal?  c. Have you or the person being vaccinated ever have Guillain-Barre Syndrome? Explain | | | | | | | | | | | | | | YES  YES  YES | | | NO  NO  NO |  | | |
| 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:** |