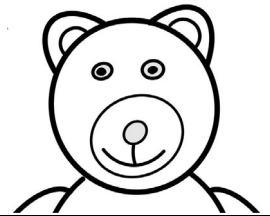




CHILD VACCINATION ADMINISTRATION RECORD

COVID-19 Vaccine

Clients 6 months through 11 years old



SECTION 1a CLIENT INFORMATION (Please PRINT clearly)

Today's Date: _____

Child's Legal Name: _____
Last Name First Name Middle Name

Date of Birth: _____ MM/DD/YYYY Other Names Used Since Birth: _____
(Previous Name, etc.):

Gender: Male Female

Race: White Asian Native Alaskan/American Indian
 Black/African American Native Hawaiian/Pacific Islander Multi-Racial (Select all that apply)

Ethnicity: Non-Hispanic/Latino Hispanic/Latino

SECTION 1b PARENT/RESPONSIBLE PARTY INFORMATION

Responsible Party Last Name: _____ Responsible Party First Name: _____

Relationship: Parent Legal Guardian Power of Attorney

Address: _____
Street Address

_____ City State Zip Code

Phone Number: _____
(Area Code) Phone Number

SECTION 2 MEDICAL SCREENING QUESTIONNAIRE

1. Is the child currently ill or running a fever? Yes No

2. Has the child received any vaccine within the past 14 days? Yes No

3. Has the child ever had a severe allergic reaction to any of the following items?
 Yes No

- A previous dose of COVID-19 vaccine or any other vaccine
- Medication or therapy, polyethylene glycol (PEG) or polysorbate
- Food item, pet, insect, latex, environmental substance or any other substance

4. Does the child have a low platelet count or a bleeding disorder? Yes No

5. Has the child previously been treated for COVID-19 with monoclonal antibodies or convalescent plasma? Yes No

SECTION 3 CONSENT

A **CONSENT FOR SERVICES:** I have read or have had explained to me, the information contained in the Emergency Use Authorization Fact Sheet regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s). I ask that the vaccine(s) be given to me, or to the person for whom I am authorized to make this request. I also authorize the Macomb County Health Department to release my immunization record information, or the immunization record information of the person for whom I am authorized to make this request to other health care provider(s) as needed and to other public health authorities (e.g. for entry into an immunization registry for Covid-19 Vaccine reporting requirements).

B **NOTICE OF PRIVACY PRACTICES:** I have received notification of the Macomb County Health Department's Notice of Health Information Practices. I understand that my acknowledgement of the Notice is evidenced by my signature on this document. The Department is required to abide by the terms of this privacy notice. The Department may change the terms of its notice at any time. The new notice will be effective for all protected health information that it maintains at that time. Upon my request, the Department will provide me with the revised notice of privacy practices.

By signing below, I hereby acknowledge that I have read and fully understand the applicable statements on this form.

SIGNATURE of Parent/Responsible Party _____ Date _____

PRINT NAME of Parent/Responsible Party _____



CHILD VACCINATION ADMINISTRATION RECORD

Office Use Only



SECTION 4 Registration Information				
Service Location	<input type="checkbox"/> 91 – MC Outreach	<input type="checkbox"/> Mount Clemens (01)	Entered in MCIR by	
	<input type="checkbox"/> 92 – SW Outreach	<input type="checkbox"/> Southwest (02)		
	<input type="checkbox"/> 93 – SE Outreach	<input type="checkbox"/> Southeast (03)	Date Entered in MCIR	

SECTION 5 Vaccine Documentation				
Vaccination Checklist	<input type="checkbox"/> Birthdate Confirmed		<input type="checkbox"/> EUA Fact Sheet Given	
	<input type="checkbox"/> Screening Questions Reviewed		<input type="checkbox"/> Provided COVID-19 Vaccination Record	

Vaccine	MFR	Lot Number/Dose/Volume	Site	Route
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PFIZER: Primary Series					
COVID-19 Vaccine mRNA, LNP-S, PF, tri-sucrose	<input type="checkbox"/> Pfizer-BNT 6 months through 4 years old	LOT #	<input type="checkbox"/> Right Arm (Deltoid) <input type="checkbox"/> Left Arm (Deltoid)	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh	IM
		<input type="checkbox"/> Dose 1 (3 mcg/0.2 mL dose) Monovalent			
		<input type="checkbox"/> Dose 2 (3 mcg/0.2 mL dose) Monovalent <input type="checkbox"/> Dose 3 (3 mcg/0.2 mL dose) Bivalent			

COVID-19 Vaccine mRNA, LNP-S, PF, tri-sucrose	<input type="checkbox"/> Pfizer-BNT 5 years through 11 years old	LOT #	<input type="checkbox"/> Right Arm (Deltoid) <input type="checkbox"/> Left Arm (Deltoid)	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh	IM
		<input type="checkbox"/> Dose 1 (10 mcg/0.2 mL dose)			
		<input type="checkbox"/> Dose 2 (10 mcg/0.2 mL dose) <input type="checkbox"/> Dose 3 (10 mcg/0.2 mL dose)*			

MODERNA: Primary Series				
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COVID-19, mRNA, LNP-S, PF, pediatric	<input type="checkbox"/> Moderna 6 months through 5 years old	LOT #	<input type="checkbox"/> Right Arm (Deltoid) <input type="checkbox"/> Left Arm (Deltoid)	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh	IM
		<input type="checkbox"/> Dose 1 (25 mcg/0.25 mL dose)			
		<input type="checkbox"/> Dose 2 (25 mcg/0.25 mL dose) <input type="checkbox"/> Dose 3 (25 mcg/0.25 mL dose)*			

COVID-19, mRNA, LNP-S, PF	<input type="checkbox"/> Moderna 6 years through 11 years old	LOT #	<input type="checkbox"/> Right Arm (Deltoid) <input type="checkbox"/> Left Arm (Deltoid)	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh	IM
		<input type="checkbox"/> Dose 1 (50 mcg/0.5 mL dose)			
		<input type="checkbox"/> Dose 2 (50 mcg/0.5 mL dose) <input type="checkbox"/> Dose 3 (50 mcg/0.5 mL dose)*			

* Dose #3 administered when client requires an Additional Dose due to an immunocompromised condition.

PFIZER: Booster				
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COVID-19, mRNA, Bivalent	<input type="checkbox"/> Pfizer-BNT 6 months through 4 years old	LOT #	<input type="checkbox"/> Right Arm (Deltoid) <input type="checkbox"/> Left Arm (Deltoid)	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh	IM
		<input type="checkbox"/> Booster Dose			

COVID-19, mRNA, Bivalent	<input type="checkbox"/> Pfizer-BNT 5 years through 11 years old	LOT #	<input type="checkbox"/> Right Arm (Deltoid) <input type="checkbox"/> Left Arm (Deltoid)	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh	IM
		<input type="checkbox"/> Booster Dose (10 mcg/0.2 mL dose)			

MODERNA: Booster				
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COVID-19, mRNA, Bivalent	<input type="checkbox"/> Moderna 6 months through 5 years old	LOT #	<input type="checkbox"/> Right Arm (Deltoid) <input type="checkbox"/> Left Arm (Deltoid)	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh	IM
		<input type="checkbox"/> Booster Dose (10 mcg/0.2 mL dose)			

COVID-19, mRNA, Bivalent	<input type="checkbox"/> Moderna 6 years through 11 years old	LOT #	<input type="checkbox"/> Right Arm (Deltoid) <input type="checkbox"/> Left Arm (Deltoid)	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh	IM
		<input type="checkbox"/> Booster Dose (25 mcg/0.25 mL dose)			

Staff Administering Vaccine	
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Date	
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PROGRESS NOTES	
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