McLaren
HEALTH MANAGEMENT GROUP

COVID-19 Vaccine Administration Request Form

Requested COVID-19 Vaccine: ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson)

SECTION A:

First Name: _____ Last Name: _____ Date of Birth: _____ Age: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Gender: ☐ Female ☐ Male Phone: _____ Email: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ethnicity

McLaren Employee: ☐ Yes ☐ No Division: _____ Volunteer: ☐ Yes ☐ No

SECTION B: *The following questions will help us determine your eligibility to be vaccinated today. Please answer questions 1-13.*

IMMUNIZATION SCREENING QUESTIONS	
1. In the past 2 weeks, have you been diagnosed with or tested positive for COVID-19?	☐ Yes ☐ No ☐ Unknown
2. In the past 2 weeks, have you been identified as a close contact to someone with COVID-19?	☐ Yes ☐ No ☐ Unknown
3. Have you had new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	☐ Yes ☐ No ☐ Unknown
4. Do you feel sick today?	☐ Yes ☐ No ☐ Unknown
5. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? Date of 1st vaccine: (_____) ☐ Pfizer ☐ Moderna ☐ Other: _____	☐ Yes ☐ No ☐ Unknown
6. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital? • If yes, was the severe allergic reaction after receiving a COVID-19 vaccine? • If yes, was the severe allergic reaction after receiving another vaccine or another injectable medication?	☐ Yes ☐ No ☐ Unknown ☐ Yes ☐ No ☐ Unknown ☐ Yes ☐ No ☐ Unknown
7. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐ Yes ☐ No ☐ Unknown
8. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐ Yes ☐ No ☐ Unknown
9. Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes ☐ No ☐ Unknown
10. Do you have a history of or a risk factor for a blood clotting disorder?	☐ Yes ☐ No ☐ Unknown
11. Are you pregnant or breastfeeding?	☐ Yes ☐ No ☐ Unknown
12. Do you have dermal fillers?	☐ Yes ☐ No ☐ Unknown
FOR THE JANSSEN (JOHNSON & JOHNSON) ONLY:	
13. I am aware of the following warning: Reports of adverse events following use of the Janssen COVID-19 Vaccine under emergency use authorization suggest an increased risk of thrombosis involving the cerebral venous sinuses and other sites (including but not limited to the large blood vessels of the abdomen and the veins of the lower extremities) combined with thrombocytopenia and with onset of symptoms approximately one to two weeks after vaccination. Most cases of thrombosis with thrombocytopenia reported following the Janssen COVID-19 Vaccine have occurred in females ages 18 through 49 years; some have been fatal.	☐ Yes ☐ No ☐ Unknown

SECTION C:

I certify that I am: (i) the patient and at least 18 years of age; (ii) the legal guardian of the patient; or (iii) individual authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. I have been provided with the manufacturer's information sheet for the vaccine. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccination administration area for 15-30 minutes after vaccination to be monitored for any potential adverse reactions. I agree to have my immunization record uploaded to the Michigan Care Improvement Registry (MCIR), sponsored by the Michigan Department of Community Health.

Signature: _____ **Date:** _____

(Signature of patient, Authorized Representative or parent/guardian - if minor)

SECTION D: To be filled out by the Administrator:

Vaccine	Manufacturer	Route	Dosage	NDC	Lot #	Site of Injection	Expiration Date	EUA Fact Sheet Provided

I have reviewed the Patient Information and Screening Questions.	Initial Here:
I have verified the patient meets the state, age and vaccination restrictions.	Initial Here:
I have verified the requested immunization(s) is the same as the product prepared.	Initial Here:
I have verified the expiration date of the product is greater than today's date.	Initial Here:

Immunizer Name (print): _____

Immunizer Signature: _____

Administration Date: _____ Date EUA fact sheet provided: _____

Date added to MCIR: _____ Date added to OHM (if applicable): _____

*** The above vaccine was administered per standing order authorized by MHCC,