McLaren
HEALTH MANAGEMENT GROUP

Vaccine Administration Request Form

Requested COVID-19 Vaccine: ☐ **Pfizer (primary)** ☐ **Moderna (primary)** ☐ **Pfizer bivalent (booster)** ☐ **Moderna bivalent (booster)** ☐ **Janssen/Johnson & Johnsen (primary)** ☐ **Other:**

Requested Influenza Vaccine: ☐ **FluLaval Quadrivalent** ☐ **Fluzone High-Dose** ☐ **Other:**_____

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: _____ Medicare B:_____

Volunteer: ☐ Yes ☐ No

SECTION B: *The following questions will help us determine your eligibility to be vaccinated today.*

IMMUNIZATION SCREENING QUESTIONS	
1. In the past 2 weeks, have you been diagnosed with or tested positive for COVID-19?	☐ Yes ☐ No ☐ Unknown
2. Do you feel sick today?	☐ Yes ☐ No ☐ Unknown
3. Do you have an allergy to a component of the requested vaccine?	☐ Yes ☐ No ☐ Unknown
4. Are you allergic to eggs?	☐ Yes ☐ No ☐ Unknown
5. Do you have a history of Guillain-Barre Syndrome (GBS)?	☐ Yes ☐ No ☐ Unknown
FOR THE COVID-19 VACCINE:	
6. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? Date(s) of vaccine: (_____) ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Other: _____	☐ Yes ☐ No ☐ Unknown
7. 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
8. Check all that apply to you: ☐ Have a history of myocarditis or pericarditis ☐ Am currently pregnant or breastfeeding ☐ Have a bleeding disorder ☐ Take a blood thinner ☐ Have received dermal fillers ☐ Have a history of heparin-induced thrombocytopenia (HIT) ☐ Have a weakened immune system or take immunosuppressive drugs or therapies ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum ☐ Diagnosed with Multisystem Inflammatory Syndrome after a COVID-19 infection	

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/VIS 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,