Wayne Health Department
475 Valley Rd, Wayne, NJ 07470
973-694-1800 ext. 3241

COVID-19 Immunization Screening and Consent Form 2023

□ **Pfizer**
□ **Pfizer Bivalent**
□ **Moderna**
□ **Moderna Bivalent**
□ **Novavax**
□ **J&J**

Name_____

Address_____
Street

_____
City State Zip Code

Phone: _____

Age: _____ Date of Birth: _____ Gender (Circle One): Male or Female
(Month/Day/Year)

Email: _____

Race (circle one): American Indian / Asian / Black / Pacific Islander / White / Other Race

Ethnicity (circle one): Hispanic / Non-Hispanic / Unknown / Prefer Not to Say

Physician: _____ **Phone#**:_____

Clinic Use ONLY
Date of Vaccination
_____

Place lot /expiration label here

Site of injection Deltoid / Thigh (circle one)
___Right

___Left

Administered by:

_____

Screening Questionnaire:

	Yes	No
1. Are you sick today?	___	___
2. Have you ever received a dose of COVID-19 vaccine? ___	___	
If yes, which vaccine product? □ Pfizer □ Moderna □ Another product		
3. 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?	___	___
- Was the severe allergic reaction after receiving a COVID-19 vaccine?	___	___
- Was the severe allergic reaction after receiving another vaccine or another injectable or medication?	___	___
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum)		

	Yes	No
5. Have you received another vaccine in the last 14 days?	___	___
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	___	___
7. Do you have a weakened immune system caused by something such as HIV infection or Cancer or do you take immunosuppressive drugs or therapies?	___	___
8. Do you have a bleeding disorder or are you taking a blood thinner?	___	___
9. Are you pregnant or breastfeeding?	___	___

Insurance Information

Name of Insured: _____

Insurance Company: _____

ID Number: _____

☐ I understand or have been explained the above information and I was given the opportunity to ask questions.

Homebound Residents

☐ I agree to and authorize that the Wayne Health Department may conduct a home visit and administer a COVID-19 vaccine.

Signature of Vaccinee/Surrogate/Guardian: _____ Date: _____

Print name of vaccinee: _____

Form reviewed by: _____
(RN/MD) Initials