DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Immunization Program

Immunization Reporting Record

All Sections Required	
Practice Name(1):	
Ordering Provider(2):	**Administering Provider**(3):
Patient Information	
Patient's Name (Last, First)(4):	**Sex** (6): □Male □Female
Patient's Address(5):	**DOB** (7): / /
	Ethnicity (8): □Hispanic □Non-Hispanic
City, State Zip Code:	
RACE(9): ☐Caucasian ☐African American ☐Asian/Pacific Islander ☐Am. Indian/Alaskan Native ☐Other (Specify):	

COVID Vaccine Information: Please Print

Vaccine Date (MM/DD/YYY) / /

Manufacturer

Vaccine Expiration Date (MM/DD/YYY) / /

Lot Number

VIS/EUA Date (MM/DD/YYY) / /

Site (Check One): RD_____ LD_____ RA_____ LA_____ RT_____ LT_____

Route (Check One): IM_____ IT_____ ID_____ NS_____ PO_____ SC_____

Priority Group / Phase

Complete the next section and sign after you have talked with the clinician.

Vaccine to be administered : O First Vaccine Shot *OR* O Second Vaccine Shot

A filled in circle next to the vaccine (above) and my signature (below) means that I have been provided a copy of the appropriate Vaccine Information Statement and have read, or have had explained to me, information about the disease and the vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I understand the risks and benefits as set forth in the statement received and I ask that the vaccine, as marked, be given.

Signature _____ Signer's Name _____

O Patient O Parent O Guardian — Print Clearly

Screening Questionnaire for 2020 COVID-19 Vaccination

The following questions will help us determine if there is any reason, we should not give you 2020 COVID-19 vaccine today. If you answer “yes” to any question, it does not necessarily mean you or your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your clinician.

Please fill in the circle next to the appropriate answer.

1.	Is the person to be vaccinated sick today?	O No O Yes O Unsure
2.	Does the person to be vaccinated have any allergies?	O No O Yes O Unsure
3.	Has the person to be vaccinated ever had a serious reaction to any vaccine?	O No O Yes O Unsure
4.	Does the person to be vaccinated have a fever?	O No O Yes O Unsure
5.	Has the person to be vaccinated previously received a 2020 COVID-19 vaccination?	O No O Yes O Unsure
6.	Has the person to be vaccinated received any other vaccinations in the past 2 weeks?	O No O Yes O Unsure
7.	Has the person ever had a severe allergic reaction (e.g., anaphylaxis) to something?A reaction for which the person was treated with epinephrine or EpiPen, or for which the person had to go to the hospital.	O No O Yes O Unsure
8.	Was the severe allergic reaction after receiving a COVID-19 vaccine?	O No O Yes O Unsure
9.	Was the severe allergic reaction after receiving another vaccine or another injectable medication?	O No O Yes O Unsure
10.	Does the person have a bleeding disorder or is taking a blood thinner?	O No O Yes O Unsure
11.	Has the person received passive antibody therapy as treatment for COVID-19?	O No O Yes O Unsure
12.	Is the person to be vaccinated pregnant or could she become pregnant within the next month?	O No O Yes O Unsure
13.	Is the person over the age of 16 (Pfizer) / Is the person over the age of 18 (Moderna)?	O No O Yes O Unsure