Effingham County Health Department
Covid – 19 Vaccination Administration Record

First Name: _____ Last Name: _____ Date: _____

DOB: _____ Age: _____ Phone Number: _____

Address: _____ City: _____ Zip Code: _____

Consent

	Yes	No
1. Is this your first dose of COVID-19 vaccine?		
2. Have you been sick or running a fever in the past 24 hours?		
3. Have you ever experienced a severe allergic reaction to any vaccine or injectable medication? If yes, you will need to stay 30 minutes for observation after vaccination.		
4. Have you had COVID in the past 60 days?		
5. Are you immunocompromised or taking a medication that affects your immune system?		

I have been offered the current COVID-19 vaccine information sheet (VIS). I have been provided education and given an opportunity to ask questions about the disease and vaccination. I understand the risks and benefits of the vaccination

I understand that the vaccine will not be fully effective for approximately two weeks. However, with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I hereby request the COVID- 19 vaccine for the 2024-2025 Respiratory season be given to myself or the person for whom I am authorized to give consent.

I authorize the Effingham County Health Department to bill my Insurance for the vaccine and administration.

I also consent to have my immunization data entered into the State of Illinois Electronic Medical Record system called I-Care.

Patient or Guardian's Signature: _____ Date: _____

Witnessed/Administered By: _____ Date: _____

CLINIC/OFFICE USE ONLY

Vaccine: Lot #: _____ Expiration Date: _____

Site: Right Left Deltoid Thigh

Eligibility: 317 Private VFC

Nurse: ASintim-Aboagye JBoone KEnloe KHowell KHughes DLueken BMiller LOhnesorge LFrost

EZ Encounter_____ EZ Charted_____ IC Check_____ Scanned_____ Updated 9/13/2024