County HEALTH Department

Last	First	M.	Age
Address	City	State MI	Zip
Phone #	Maiden Name	Birth Date / /	

Gender ☐ Male ☐ Female

Race ☐ Caucasian ☐ Hispanic ☐ African American ☐ Other

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Other

Insurance Type _____

Card Holder Name: _____ Card Holder Birth Date: _____

Enrollee ID _____ Group # _____

Medicare # _____ Medicaid # _____

	Yes	No
1. Are you feeling sick today?		
2. Have you ever received a dose of COVID-19 vaccine?		
• **If yes, which vaccine product did you receive?** ☐ **Pfizer** ☐ **Moderna** ☐ **Janssen (Johnson & Johnson)** ☐ **Another product** _____		
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)		
• **A component of the COVID-19 vaccine including either of the following:**		
○ **Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures**		
○ **Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids**		
• **A previous dose of COVID-19 vaccine**		
• **A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.**		
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)		
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.		
6. Have you received any vaccine in the last 14 days?		
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?		
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
10. Do you have a bleeding disorder or are you taking a blood thinner?		
11. Are you pregnant or breastfeeding?		
12. Do you have dermal fillers?		

SIGNATURE _____ **Legal Guardian Name:** _____

EMAIL: _____ **Date:** _____

For Office Use Only

☐ **COVID-19 Lot #** _____ **Site** _____ **Manufacturer** _____ **Signature** _____