NORTON SOUND HEALTH CORPORATION

COVID-19 & Influenza Vaccination Administration Form

Patient Name (Print): ______________________ Date of Birth: ______________________

Address: ______________________ Phone Number: ______________________

Vaccination Screening Questions

	Circle the answer:		
Have you ever had shortness of breath, difficulty breathing, or any other severe allergic reaction to a vaccine or injectable medication?	YES	NO	Do not Know
Does the person to be vaccinated have an allergy to a component of the vaccine?	YES	NO	Do not Know
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	YES	NO	Do not Know
Has the person to be vaccinated ever had Guillain-Barre syndrome?	YES	NO	Do not Know

I have received, read, and understand either the emergency use authorization fact sheet provided or the VIS. I understand the risks involved with receiving the vaccine. I have had the opportunity to ask any questions and have received answers to my satisfaction.

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Signature Date

FOR OFFICE USE ONLY:

Date Administered	Site ARM LEG	Manufacturer	Lot #
/ /	R L	COVID -	
/ /	R L	INFLUENZA -	
Signature of Vaccine Administrator:			