HAMILTON COUNTY PUBLIC HEALTH
PREVENT. PROMOTE. PROTECT.

Attestation For Administration of COVID-19 Vaccine Per Emergency Use Authorization

(Please PRINT Clearly)

Full Legal Name: _____

Date of Birth _____/_____/_____
MM DD YYYY

Race (Check One):
- ❑ White
- ❑ Black or African American
- ❑ Asian
- ❑ American Indian or Alaska Native
- ❑ Native Hawaiian or Other Pacific Islander

Ethnicity (Check One):
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino

Sex (Check One): ❑ Male ❑ Female

Target Population or Occupation: _____

Contact Information:

Phone Number: (_____-_____-_____)

Email Address: _____

Address: _____
Street Address

_____
City, State, Zip Code

Vaccination Location: _____

1.	Do you currently have an active infectious or acute respiratory illness, or fever?	❑ Yes	❑ No
2.	Have you ever had a severe allergic reaction to any of the vaccine ingredients listed in the EUA Fact Sheet or in other vaccine documents provided to you?	❑ Yes	❑ No
3.	Have you received any other vaccines within the past 14 days?	❑ Yes	❑ No

I understand that the COVID-19 vaccine I am receiving is being administered to me pursuant to a U.S. Food and Drug Administration Emergency Use Authorization (EUA). I have received and read the EUA Fact Sheet for recipients of this vaccine (and/or other vaccine documentation provided to me), which fully explains to me the risks and benefits of receiving this vaccine. I agree that Hamilton County Public Health (HCPH) has not made any guarantees to me about the result(s) of this vaccination, and I understand that I may experience side effect(s) after receiving this vaccine. If required depending on the vaccine manufacturer; I further understand that if this vaccine needs to be administered as a 2-dose series, I agree that I will promptly schedule my second-dose appointment as indicated.

I agree that it is my personal decision to receive this EUA COVID-19 vaccine, and I give HCPH permission to administer this vaccine to me. By signing below, I further confirm that: I have read this Attestation or had it effectively communicated to me; any questions I may have had about it or the vaccine document(s) provided to me by HCPH have been answered to my satisfaction; I understand and accept all terms of this Attestation; I am the individual identified, above, or his/her authorized personal representative; I am at least 18 years of age; and that I have signed this Attestation voluntarily.

Signature of patient or parent/legal guardian: _____ Date: _____

FOR OFFICE USE ONLY Vaccine Administered Per EUA					
Vaccine Manufacturer:	Pfizer-BioNTech	Moderna	❑ AstraZeneca	❑ Other	DOSE 1 Lot # _____
Route/Site:	❑ IM - Left Deltoid	❑ IM - Right Deltoid			Exp. Date _____
Vaccine Documents provided by BSMH:	❑ EUA Fact Sheet for Recipient		❑ Vaccination record card		DOSE 2 Lot # _____ Exp. Date _____

DOSE 1 Administered by (PRINT FULL NAME): _____	DOSE 2 Administered by (PRINT FULL NAME): _____
Administrator Signature: _____	Administrator Signature: _____
Date/Time Administered Dose 1: _____	Date/Time Administered Dose 2: _____

Last edited 3/17/21

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name _____

Age _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
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 ☐ 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 polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
• Polysorbate			
• A previous dose of COVID-19 vaccine			
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, polysorbate, or any vaccine or injectable medication? This would include food, pet, 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?			

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists