<u>Boulder County Public Health</u>
SARS-CoV-2 (COVID-19) VACCINE

Date ______________ Clinic Location:____

Patient Name: ____ Birthdate ________________

Address ____Patient Phone # ______________

SSN: ______-_____-_________ **Sex** (Circle One)**:** Male Female X Nonbinary Unknown

Race (Circle One)**:** American Indian Asian African American Hispanic Other White

Ethnicity: Hispanic Not Hispanic Unknown

Below this line for Clinic downtime use only

Immunization: ____ Lot #: _______________________

Dose : _____ mL Route: <u>IM</u> NDC: ____________________________ Expiry: ________________

Site: Left Deltoid Right Deltoid Other:________________

Are you sick today with a moderate to severe illness (fever, chills, shortness of breath, loss of taste or smell?)

YES NO

Have you ever had an immediate allergic reaction of any severity to a vaccine/injectable therapy or anaphylaxis from any cause? (YES=30min recovery)

YES NO

Have you ever had an allergic reaction to polythylene glycol (PEG) or polysorbate? (YES=Do not administer mRNA COVID-19 vaccine; Pt to review with allergist)

YES NO

(For Clinic Use)
Vaccine Label