PREVENT. PROMOTE. PROTECT.

Attestation For Administration of COVID-19 Vaccine

(Please PRINT Clearly)

Full Legal Name: ______________________________ **Date of Birth:** __________/__________/__________
MM DD YYYY

Phone Number: ____________________________ **Email Address:** _________________________________

Gender Identity (Check One):
☐ Male
☐ Female
☐ Self Describe: ____________________________

Address: ______________________________________
Street Address

____
City, State, Zip Code

Race:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

Ethnicity (Check One):
☐ Hispanic or Latino
☐ Not Hispanic or Latino

I understand that the COVID-19 vaccine I am receiving is being administered to me pursuant to the Food and Drug Administration (FDA) approval and/or Emergency Use Authorization. I have received and read the 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 adhere to the guidance and receive the second dose within the recommended time frame.

I agree that it is my personal decision to receive this 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 their authorized personal representative; I am at least 18 years of age; and that I have signed this Attestation voluntarily.

Signature of Patient or Legal Guardian: ___________________________________ **Date:** ________________

Please complete the questionnaire on the back of this form.

FOR OFFICE USE ONLY Vaccine Administration					Vaccination Site: ______________________________	
Vaccine Manufacturer:	☐ Pfizer-BioNTech	☐ Moderna	☐ Jansen (J&J)	☐ Other: __________	Vaccine Documents provided by HCPH: ☐ EUA/FDA Fact Sheet for Recipient ☐ Vaccination Record Card	
Route/Site:	☐ IM - Left Deltoid	☐ IM - Right Deltoid	☐ Other: ______________			

DOSE # ____ Administered by (PRINT FULL NAME): ____________________	DOSE # ____ Administered by (PRINT FULL NAME): ____________________
Administrator Signature: ______________________________	Administrator Signature: ______________________________
Date/Time Administered Dose: ____________________________	Date/Time Administered Dose: ____________________________
Lot #: ____________________ Expiration Date: ________________	Lot #: ____________________ Expiration Date: ________________
DOSE # ____ Administered by (PRINT FULL NAME): ____________________	DOSE # ____ Administered by (PRINT FULL NAME): ____________________
Administrator Signature: ______________________________	Administrator Signature: ______________________________
Date/Time Administered Dose: ____________________________	Date/Time Administered Dose: ____________________________
Lot #: ____________________ Expiration Date: ________________	Lot #: ____________________ Expiration Date: ________________

Last Edited: 7 June 2022

Prevaccination Checklist for COVID-19 Vaccination

Name ____________________

For vaccine recipients:

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.

Question	Yes	No	Don't know
1. How old are you? ____________			
2. Are you feeling sick today?	☐	☐	☐
3. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product(s) did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product ____________			
• How many doses of COVID-19 vaccine have you received? ____________			
• Did you bring your vaccination record card or other documentation?	☐	☐	
4. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.*	☐	☐	☐
5. Have you received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. 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 caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. 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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

8. Check all that apply to you:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months?

Form reviewed by ____________________ **Date** ____________