Vaccination Registration Form

(please write/print neatly)

Full Legal Patient Name: _____

Date of Birth: _____

Gender: ☐ Male ☐ Female ☐ Unknown

Address: _____

Phone Number: _____

Race (select one):

☐ Black ☐ Native American ☐ Asian ☐ Refused

☐ Unknown ☐ White ☐ Other Pacific Islander ☐ Other:_____

Ethnicity/Hispanic Origin (select one):

☐ Hispanic ☐ Non-Hispanic ☐ Other ☐ Unknown

☐ Refused

Agency:

☐ Falls Community Health ☐ The Arch ☐ Bishop Dudley Hospitality House

☐ Glory House ☐ St. Francis ☐ Union Gospel Mission

☐ City of Sioux Falls

Priority Group

☐ Phase 1 Group C
- Other healthcare workers
- Public Health workers
- Emergency Medical Services
- Law Enforcement
- Correctional Officers

☐ Phase 1 Group D
- Persons aged 65 years and older
- High risk patients
- High risk residents in congregate settings
- Persons with 2 or more underlying medical conditions
- Teachers and other school/college staff
- Funeral Service workers

☐ Phase 1 Group E
- Fire Service Personnel
- Other Critical Infrastructure Workers

☐ Phase 2 - all others not listed above

This form to be used at the City of Sioux Falls

City of Sioux Falls 2020-2021 COVID-19 Screening and Vaccine Administration Record

Please Answer These Questions:

		Yes	No
1.	Are you under the age of 18? (If you are under 18, you must have a parental consent to receive the vaccine). If the named individual is **under the age of 18**, as parent or guardian I acknowledge receipt of the Emergency Use Authorization and consent to have the Pfizer vaccine administered to him/her. Parent/Guardian signature: _____	☐	☐
2.	Are you sick today?	☐	☐
3.	Have you been diagnosed with COVID in the last 10 days and are currently on isolation?	☐	☐
4.	Have you received monoclonal antibodies or convalescent plasma in the last 90 days for the treatment of COVID-19?	☐	☐
5.	Do you have HIV, other immunocompromising conditions or take immunosuppressive medication or therapies?	☐	☐
	a. If yes, have you discussed and received counseling regarding COVID-19 vaccination from your physician?	☐	☐
6.	Do you have an allergy to a component of the vaccine? (Refer to the EUA Fact Sheet.)	☐	☐
7.	Have you had a serious allergic reaction or anaphylaxis to a prior vaccine or other injected medicine (intravenous, subcutaneous, or intramuscular)?	☐	☐
8.	Are you pregnant or breastfeeding?	☐	☐
	a. If yes, have you discussed and received counseling regarding COVID-19 vaccination from your physician?	☐	☐
9.	Have you received any other vaccine in the last 14 days or intend to receive another vaccine in the next 14 days?	☐	☐

I received and read the EUA (Emergency Use Authorization) fact sheet information regarding the possible side effects, risks, and contraindications of the COVID-19 vaccine. The City of Sioux Falls will disclose this immunization to the appropriate State Immunization Registry Database.

Vaccine: COVID-19	EUA (Emergency Use Authorization):		
Date and Time Vaccine Administered	Vaccine Manufacturer/Lot Number/Expiration Date	Site	Signature and Title of Vaccine Administrator
		IM Deltoid: Location (circle one) Left Right	

Observation Time (circle one): 15 minutes 30 minutes