Program
Immunizations
Location

Prince George's County Health Department

Date		
Month	Day	Year

FLU/COVID-19
VACCINE ADMINISTRATION RECORD
Please Print

Client Name (Last) (First) (M.I)	Medical Record Number (Office Use Only)
	_____
Street Address / **Apartment Number**	**Date of Birth** (Month / Day / Year)
City / **State**	**Age** (Office Use Only) / **Sex** (Circle One)
	Male Female
Zip Code / **Are you a Health Department Employee?** (YES / NO)	**Are you Hispanic or Latino?** ☐ Yes ☐ No
	Race Select one of the following races. If you are multiracial, check all that apply: ☐ American Indian ☐ White ☐ Asian ☐ Other: _____ ☐ Black/ African American ☐ Native Hawaiian/ Pacific Islander
Phone Number / **Email**	
Parent/ Legal Guardian/ Custodian / Mother's Maiden name	Relationship to Client

	CIRCLE ONE		COMMENTS
1. Are you or the person being vaccinated sick today?	YES	NO	
2. Do you or the person being vaccinated have a fever today?	YES	NO	
3. Are you or the person being vaccinated allergic or sensitive to latex?	YES	NO	
4. Are you or the person being vaccinated pregnant?	YES	NO	
5. Is this the first FLU or COVID-19 vaccination received?	YES	NO	
6. Is the recipient breastfeeding?	YES	NO	
7. Have you or the person being vaccinated ever had a severe allergic reaction (e.g., anaphylaxis) after receiving **Flu or COVID-19** vaccine.	YES	NO	
8. **FOR FLU ONLY**			
a. Are you allergic to egg or egg products? Explain	YES	NO	
b. Are you allergic to any medication or thimerosal?	YES	NO	
c. Have you or the person being vaccinated ever have Guillain-Barre Syndrome? Explain	YES	NO	
9. **FOR COVID ONLY**	YES	NO	
a. Do you or the person being vaccinated test positive for COVID-19 in the past few days?			
b. Do you or the person being vaccinated have a bleeding disorder or taking blood thinners?			
c. Have you or the person being vaccinated received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 in the past 90 days?	YES	NO	

Recipient Signature/ Parent or Guardian	Date:

This person qualifies for vaccinations through the Maryland VFC (Vaccines) Program because he/she:
(Please check one of the following boxes):

☐ a. Is covered by or enrolled in Medical Assistance (United Healthcare, Priority Partners, Amerigroup, etc.) OR
☐ b. Does not have health insurance, OR
☐ c. Is Native American (American Indian) or Alaskan Native, OR
☐ d. Has health insurance that does not cover (pay for) vaccines.

FOR NURSES ONLY

Vaccine Manufacturer	Vaccine Lot Number	Expiration Date	Injection Site	Date Administered	Vaccine Administrator Signature
INFLUENZA					
Vaccine Manufacturer	**Vaccine Lot Number**	**Expiration Date**	**Injection Site**	**Date Administered**	**Vaccine Administrator Signature**
COVID-19					

Nurse Signature & Date		Comments: