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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

BUREAU OF PUBLIC HEALTH PROTECTION

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I have been given and have reviewed the FDA Fact Sheet for the COVID-19 vaccine that I am receiving today. I have also been given and have reviewed the New Hampshire Department of Health and Human Services (NH DHHS) "Notice of Privacy Practices."

I understand unless I have signed the separate Opt-out form exercising my right under New Hampshire RSA 141-C:20-f, that as a condition of receiving the COVID-19 vaccine today my personal immunization information will be shared with the Centers for Disease Control and Prevention (CDC) and the NH Immunization Program (NHIP) for public health purposes and for other purposes allowed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing below, I am acknowledging that I have received and reviewed the information provided, and I agree to be vaccinated with the COVID-19 Vaccine.

_____ _____

Print Name Date

_____

Signature

The Department of Health and Human Services' Mission is to join communities and families in providing opportunities for citizens to achieve health and independence.

GREATER SEACOAST COMMUNITY HEALTH

STRAFFORD COUNTY PUBLIC HEALTH NETWORK

Registration and Pre-vaccination Questionnaire

Please complete all sections before going to the clinic. Please print clearly.

CLINIC NAME or LOCATION: _____

First name *(given name)*				
Last name *(family name)*				
Date of Birth	_____/_____/_____			
Parent/Guardian Name & Relationship Providing Consent *(if minor)*				
Gender *(mark with an X)*	Male	Female	Unknown/ Unreported	Other
Ethnicity *(mark with an X)*	Hispanic or Latino/a	Not Hispanic or Latino/a		Don't Know/ Unreported
Race *(check all that apply)*	American Indian or Alaska Native	Asian		Black or African American
	Native Hawaiian or Pacific Islander	White		Unknown/ Unreported
Home address: Street				
Home address: City				
Home address: State				
Home address: Zip Code				
Email address:				

FOR OFFICE USE ONLY

Vaccinator: Write vaccine type & lot number here: _____ _____

What **dose number** is this? DOSE 1 DOSE 2 DOSE 3 BOOSTER

What **date & time** was the dose administered? _____

Which **arm** was the dose administered in: LEFT or RIGHT

Logger: Initial when vaccine logged _____

NH DIVISION OF Public Health Services
Department of Health and Human Services

Medical Screening Questionnaire *Updated 3/1/2022*

Bureau of Infectious Disease Control

General Medical Screening Questions for All Ages

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine. If you answer "yes" to any of the questions, it does not necessarily mean you should not be vaccinated. It just means additional information may be needed. Please answer the questions below for the person who is receiving the vaccine.

Name of Person Receiving the Vaccine: _____

Date of Birth: _____ **Age:** _____

COVID-19 Vaccine Being Administered: ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen (Johnson & Johnson)

	Yes	No	Don't Know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of a COVID-19 vaccine before? **If yes**, which COVID-19 vaccine product(s) were you previously given? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Other	☐	☐	☐
3. Did you have an allergic reaction after a prior dose of any COVID-19 vaccine? (*Allergic reactions can include symptoms like rash, hives, swelling of the face or mouth, wheezing and difficulty breathing, etc.*) **If yes**, please specify the specific vaccine AND your allergic reaction: _____	☐	☐	☐
4. Do you have a known allergy to an ingredient in the COVID-19 vaccine that you will be receiving today? *(See the provided FDA Fact Sheet for a list of vaccine ingredients)*	☐	☐	☐
5. Do you have a known allergy to polyethylene glycol (PEG)?	☐	☐	☐
6. Do you have a known allergy to polysorbate?	☐	☐	☐
7. Have you ever had any allergic reaction within 4 hours of receiving a non-COVID-19 vaccine or ot injectable ıer medication (including medications injected into a muscle, vein, or under the skin)?	☐	☐	☐
8. Have you ever had a severe allergic reaction (like anaphylaxis) due to any other cause, including medications taken by mouth, food, or other substances? o	☐	☐	☐
9. Did you develop myocarditis or pericarditis after receiving a prior dose of either the Pfizer-BioNTech or Moderna COVID-19 vaccine?	☐	☐	☐
10. Do you have a bleeding disorder or are you taking blood thinners?	☐	☐	☐
11. Do you have a health condition that weakens your immune system and makes you moderately or severely immunocompromised?	☐	☐	☐
12. Have you ever developed an immune-related health condition that caused blood clotting AND lo *he most* platelet blood counts? *common example of this is called "heparin-induced thrombocytopenia"*) v	☐	☐	☐
13. Did you develop a health condition called "Thrombosis with Thrombocytopenia Syndrome" (TTS) after receiving a prior dose of the Janssen or AstraZeneca COVID-19 vaccines? (*People with TTS develop blood clotting and low platelet blood counts after COVID-19 vaccination*)	☐	☐	☐
14. Did you develop Guillain-Barré syndrome (GBS) after receiving a prior dose of the Janssen vaccine?	☐	☐	☐

Please sign below to confirm that the information on this form is accurate to the best of your knowledge:

Signature of Vaccine Recipient: _____ **Date**: _____