COVID-19

Vaccine Administration Record

The government requires that vaccination providers report information on individuals who receive the COVID-19 vaccine. The purpose of reporting is to determine if a person is due for the first or second dose of vaccine and to help ensure that first and second doses are administered using the same vaccine product and appropriately spaced according to recommended intervals. If you receive the vaccine, you acknowledge you are consenting to OSF reporting your vaccination in OSF's electronic medical record (EPIC) and to your state immunization registry.

PLEASE PRINT:

Last Name (Legal):	First Name (Legal):	Date of Birth:
OSF Company Name: (MSS, Ministry, etc.) Saint Anthony College of Nursing	OSF Department Name: Saint Anthony Coll of Nrsg	Employee ID #: Nursing Student

Job Responsibilities (circle one): Clinical or Non-Clinical **Gender** (circle one): Male or Female

Race: (circle one): American Indian/Alaskan Native Asian Black or African American Native Hawaiian

Other Pacific Islander Hispanic or Latino White Unknown Other

Ethnicity (circle one): Hispanic/Latino Not Hispanic or Latino Unknown

Section I: Accept Vaccine

❒ **I accept the COVID-19 Vaccine** I have read or had explained to me the Emergency Use Authorization (EUA)

Yes No

❒ ❒ I have had an allergic reaction to: (circle all that apply) food, pet, insect stings, medications, polysorbate 80, other polysorbates, or polyethylene glycol.

*Currently, if you have an allergy to polyethylene glycol you are unable to receive any COVID-19 vaccine. *Please see Section III-Medical Exemptions*

Section II: Temporary Deferral

❒ **I am requesting a temporary deferral from this vaccine. Indicate reason(s) below.**

❒ **I understand that additional documentation from my provider is required for deferral review and approval.**

Yes No

❒ ❒ I am currently experiencing a cough, fever, or headache associated with COVID-like symptoms, COVID illness, or other infection. Date of illness onset: ____________________

❒ ❒ I have recently received immunosuppressive therapy and I am severely immunocompromised, (i.e. chemotherapy). Date of treatment: ____________________

❒ ❒ I am currently pregnant. Date of positive pregnancy: ______________

❒ ❒ I have received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days. Date of treatment: ____________________

Section III: Declination- I am requesting an exemption from this vaccine. I understand that although OSF is taking precautions to prevent the spread of COVID-19, I may be at an increased risk of acquiring COVID-19 by coming in contact with someone who has COVID-19, and this may put myself and others at risk for infection.

❒ Religious Exemption to be submitted to Occupational Health (occ.health@osfhealthcare.org) and then to Human Resources for review

❒ Medical Exemption requires supportive documentation from a healthcare provider and will be reviewed for validity by a licensed medical professional within Occupational Health. HR processes may apply in some circumstances.

Signature: ______________________________ Date: ______________________________

Office Use only

Date Vaccinated	Manufacturer	Lot#	Exp. Date	Injection Site	Vaccinator's Information	
					Signature	Title
1 ________				L-Delt R-Delt		
2 ________				L-Delt R-Delt		

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