

# COVID-19 Vaccine Documentation/Consent Form

## Patient Information (Please print legibly)

<b>Last Name:</b> _____ <b>First Name:</b> _____ <b>Middle:</b> _____ <b>Date of Birth:</b> _____ <b>Sex:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <b>Address:</b> _____ <b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____ <b>Phone:</b> _____ <b>Email:</b> _____ <b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown or Not Reported <b>Ethnicity:</b> <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Unknown/Not Reported <b>*Please attach copy of insurance card    Ins Type:</b> _____	I have been offered a copy of the COVID-19 Emergency Use Authorization (EUA). I have read, had explained to me, and understand the information in the EUA. I ask that the vaccine be administered to me. I consent to inclusion of this immunization data in the Kansas Immunization Information System (KSWebIZ) for myself.  I, the undersigned, certify that all the above information is correct to the best of my knowledge. I have been offered a Notice of Thomas County Health Department Privacy Practices.  <b>Signature:</b> _____ <b>Date:</b> _____
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## Screening Questionnaire

<p><b>COVID-19 Screening Questions</b></p> <ol style="list-style-type: none"> <li>1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>2. In the past two weeks, have you had contact with anyone who tested positive for COVID-19? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>3. Do you currently or have you in the past two weeks had a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea? <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Patient temperature:</b> _____ <b>Date:</b> _____</li> </ol> <p><b>Immunization Screening Questions</b></p> <ol style="list-style-type: none"> <li>1. Are you sick today (cold, fever, acute illness)? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>2. Do you have any allergies to medications, food, a vaccine, latex, polyethylene glycol (PEG) or polysorbate? <input type="checkbox"/> Yes <input type="checkbox"/> No _____</li> <li>3. Have you had a serious reaction to a vaccine in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>4. Have you ever had Guillain-Barre syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>5. Are you pregnant or is there a chance you could become pregnant in the next month or are you breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>6. Do you have a blood-clotting disorder or are currently taking blood thinners? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ol>	<ol style="list-style-type: none"> <li>7. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Circle or list:</b> _____</li> <li>8. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease or other condition that makes it hard for you to fight infections? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Circle or list:</b> _____</li> <li>9. Do you have a weakened immune system or in the past 3 months, taken medications that weaken it such as cortisone, prednisone, other steroids, anti-cancer drugs or radiation treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>10. During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>11. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? <input type="checkbox"/> Yes <input type="checkbox"/> No _____</li> <li>12. In the past 4 weeks, have you received any vaccinations or a TB skin test? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>13. Have you previously received a vaccination for COVID-19? <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, which vaccine: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen/J&amp;J <input type="checkbox"/> Novavax          If yes, what were the approximate dates: 1<sup>st</sup> _____ 2<sup>nd</sup> _____  <b>BOOSTER:</b> _____       </li> </ol>
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## For Office Use Only

Vaccine: COVID-19	Route: _____ Dose: _____	EUA Date: _____	Site: Deltoid <input type="checkbox"/> Left <input type="checkbox"/> Right
Manufacturer: _____	1st: _____ 2nd: _____ 3rd: _____	Administered By: _____	
Lot Number: _____	Booster: # _____	Date Given: _____	Time Given: _____
Expiration Date: _____		WEBIZ: _____	SCANNED: _____ BILLED: _____