COVID-19 Vaccine Documentation/Consent Form

Patient Information (Please print legibly)

Last Name: _____ **First Name:** _____ **Middle:** ____
Date of Birth: _____ **Sex:** ☐Female ☐Male
Address: _____ **City:** _____
State: _____ **Zip:** _____ **Phone:** _____
Email:_____
Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown or Not Reported
Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Unknown/Not Reported
***Please attach copy of insurance card** **Ins Type:** _____

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.

Signature:_____
Date: _____

Screening Questionnaire

COVID-19 Screening Questions

1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19? ☐***Yes*** ☐***No***
2. In the past two weeks, have you had contact with anyone who tested positive for COVID-19? ☐***Yes*** ☐***No***
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? ☐***Yes*** ☐***No***
   Patient temperature: _____ **Date:** _____

Immunization Screening Questions

1. Are you sick today (cold, fever, acute illness)? ☐***Yes*** ☐***No***
2. Do you have any allergies to medications, food, a vaccine, latex, polyethylene glycol (PEG) or polysorbate? ☐***Yes*** ☐***No*** _____
3. Have you had a serious reaction to a vaccine in the past? ☐***Yes*** ☐***No***
4. Have you ever had Guillain-Barre syndrome? ☐***Yes*** ☐***No***
5. Are you pregnant or is there a chance you could become pregnant in the next month or are you breastfeeding? ☐***Yes*** ☐***No***
6. Do you have a blood-clotting disorder or are currently taking blood thinners? ☐***Yes*** ☐***No***
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? ☐***Yes*** ☐***No*** **Circle or list:**_____
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? ☐***Yes*** ☐***No*** **Circle or list:**_____
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? ☐***Yes*** ☐***No***
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? ☐***Yes*** ☐***No***
11. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? ☐***Yes*** ☐***No*** _____
12. In the past 4 weeks, have you received any vaccinations or a TB skin test? ☐***Yes*** ☐***No***
13. Have you previously received a vaccination for COVID-19? ☐***Yes*** ☐***No***
    If yes, which vaccine: ☐ **Pfizer** ☐ **Moderna** ☐ **Janssen/J&J** ☐ **Novavax**
    If yes, what were the approximate dates: 1st_____ 2nd_____
    BOOSTER: _____ _____ _____

For Office Use Only

Vaccine: COVID-19 **Route:** _____ **Dose:** _____ **EUA Date:** _____ **Site:** Deltoid ☐ *Left* ☐*Right*
Manufacturer: _____ 1st:____ 2nd:____ 3rd:____ **Administered By:** _____
Lot Number: _____ Booster: #_____ **Date Given:** _____ **Time Given:**_____
Expiration Date: _____ **WEBIZ:**_____ **SCANNED:** _____ **BILLED:**_____