COVID-19 Vaccine Documentation/Consent Form

Patient Information (Please print legibly)

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Date of Birth: _____ **Biological Sex:** ☐ Female ☐ Male ☐ Unknown or Not Reported

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino (Central/South America, Mexico, Cuba, Puerto Rico, Other)
☐ Unknown/Not Reported

Race 1: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown or Not Reported

Race 2: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown or Not Reported

Race 3: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown or Not Reported

Residential Address: _____ **City:** _____ **State:** _____

Zip: _____ **County:** _____

Phone: _____ **Email:** _____

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*
4. 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 or latex? ☐ *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? ☐ *Yes* ☐ *No*
6. Are you currently breastfeeding? ☐ *Yes* ☐ *No*
7. Do you have a blood-clotting disorder or are currently taking blood thinners? ☐ *Yes* ☐ *No*
8. 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*
9. 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*
10. 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*
11. 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*
12. In the past 2 weeks, have you received any vaccinations or a TB skin test? ☐ *Yes* ☐ *No*
13. Do you have a disability? ☐ *Yes* ☐ *No*

Adults of any age with **certain underlying medical conditions** are at increased risk for severe illness from the virus that causes COVID-19. This list is not all-inclusive – there may be other conditions which increase one's risk for developing severe illness from COVID-19.

- Asthma (moderate to severe)
- Cancer
- Cerebrovascular disease (affects blood vessels and blood supply to the brain)
- Chronic kidney disease
- COPD (Chronic Obstructive Pulmonary Disease)
- Cystic fibrosis
- Diabetes mellitus- type 1
- Diabetes mellitus- type 2
- Down Syndrome
- Heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
- Hypertension (high blood pressure)
- Immunocompromised state (weakened immune system) from solid organ transplant
- Immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune-weakening medicines
- Liver disease
- Neurologic conditions, such as dementia
- Obesity (body mass index [BMI] of 30 kg/m2 or higher but < 40 kg/m2) or Severe Obesity (BMI > 40 kg/m2)
- Overweight (BMI > 25 kg/m2, but < 30 kg/m2)
- Pregnancy
- Pulmonary fibrosis (having damaged or scarred lung tissues)
- Sickle cell disease
- Smoking
- Thalassemia (a type of blood disorder)

Please check one box below:

☐ I attest that I have one of the conditions listed above.

☐ I attest that I have a chronic health condition which places me at increased risk of severe illness if I get COVID-19.

☐ I attest that I am the adult caregiver of a child <16 years of age with a chronic health condition that places the child at increased risk of severe illness if infected with COVID-19.

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.

_____ _____

Signature of Patient *Date*

_____ _____

Printed Name of Patient *Date of Birth*

If patient is a minor:

_____ _____

Signature of Parent/Guardian *Date*

_____

Printed Name of Parent/Guardian

For Office Use Only

Vaccine: COVID-19 **Route:** Intramuscular **Dose:** ___ mL

Manufacturer: ☐ Moderna ☐ Pfizer ☐ J&J ☐ Other _____

Lot Number: _____ **Site:** Deltoid ☐ *Left* ☐ *Right*

Expiration Date: _____ ☐ *Other* _____

Administered By: _____ **Date Given:** _____

Signature and Title of Vaccine Administrator