Client # _____

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*

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*

CLERICAL ONLY:
NN: _____
WebIZ: _____

CLINICAL ONLY:
NN: _____
WebIZ: _____

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 4 weeks, have you received any vaccinations or a TB skin test? ☐ *Yes* ☐ *No*
13. Do you have a disability? ☐ *Yes* ☐ *No*

For my booster dose I choose: ☐ Moderna ☐ Pfizer

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