

Vaccine Administration and Screening Form

Please print neatly in capital letters as shown in the example below

E	X	A	M	P	L	E	1	2	3
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Please answer all questions as completely as possible

Use reverse side for notes

Personal Information. Provide information as completely as you can. All information will be kept confidential.

Last Name										First Name										MI	Gender			
<input type="text"/>										<input type="text"/>										<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F			
Street No. or PO Box					Street Name															Apt. Number				
<input type="text"/>					<input type="text"/>															<input type="text"/>				
City															County					State				
<input type="text"/>															<input type="text"/>					<input type="text"/>				
Zip Code					Phone					E-mail														
<input type="text"/>					<input type="text"/>					<input type="text"/>														
Date of Birth					Race/Ethnicity (Check all that apply)															<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White <input type="checkbox"/> Other				
<input type="text"/>					<input type="checkbox"/> Asian <input type="checkbox"/> Black, African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native																			

Health Screening Questions **Footnotes for precautions/contraindications are on other side of this document**

	Yes*	No
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a serious allergy to food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction to a previous dose of vaccine or any medication?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had severe allergic reaction to any component of either the Pfizer-BioNTech or the Moderna vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you pregnant, or is there a chance you may become pregnant in the next 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you received any vaccinations in the last 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you been ill with or recovered from a COVID infection or had antibody therapy in the past 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any of the following illnesses or conditions? Chronic lung disease (including asthma), heart disease, diabetes, brain, spinal cord or muscle illness that causes swallowing or lung problems, problems with the immune system caused by medications and/or HIV, kidney disease, liver disease, blood disorders	<input type="checkbox"/>	<input type="checkbox"/>

Please identify Phase Category you are in (please choose only one)

<input type="checkbox"/> 1A-Highest risk: Direct contact w COVID patients, LTC staff/residents	<input type="checkbox"/> 2-Higher risk and essential workers: Age 65 or older, or Individuals: 1) With underlying health conditions; 2) In direct contact with the public; 3) Working in or serving people in high density settings; 4) Health care workers not included in Phase 1, and; 5) Who received the placebo in Clinical Trials.
<input type="checkbox"/> 1B-Moderate Risk: EMS, Fire, Police, Corrections, HH/hospice workers, Dental, other first responders, funeral services, COVID response personnel, Health care workers with less direct contact with COVID-19 patients	<input type="checkbox"/> 3-General Public: Age 18-64 without high-risk conditions

Authorization to Administer COVID Vaccine

I have read or had explained to me, and I understand the risks and benefits of receiving the vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I hereby release this provider, its employees and its volunteers from any liability for any results which may occur from the administration of this vaccine.

Patient, Parent/Guardian Signature: _____ Date: _____

STOP DO NOT WRITE BELOW THIS LINE

COVID/VFC PIN		Clinic Name		Provider Type: <input type="checkbox"/> Public <input type="checkbox"/> Private		Prescribing Provider Name									
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>									
Manufacturer		Dosage		Lot No.						Site:		Date Administered			
<input type="checkbox"/> PFR (Pfizer) <input type="checkbox"/> AstraZeneca/Oxford Biomedica <input type="checkbox"/> Moderna <input type="checkbox"/> J&J <input type="checkbox"/> SP/GSK		<input type="checkbox"/> 0.3 ml <input type="checkbox"/> 0.5 ml		<input type="text"/>						<input type="checkbox"/> RD <input type="checkbox"/> RT <input type="checkbox"/> LD <input type="checkbox"/> LT		<input type="text"/>			
Administered by:															
Name _____										Title _____					

Precautions/Contraindications for vaccination

Triage of persons presenting for vaccination with either Pfizer-BioNTech or the Moderna COVID-19 vaccine

	MAY PROCEED WITH VACCINATION	PRECAUTION TO VACCINATION	CONTRAINDICATION TO VACCINATION
CONDITIONS	CONDITIONS <ul style="list-style-type: none"> Immunocompromising conditions Pregnancy Lactation 	CONDITIONS <ul style="list-style-type: none"> Moderate/severe acute illness 	CONDITIONS <ul style="list-style-type: none"> None
	ACTIONS <ul style="list-style-type: none"> Additional information provided 15 minute observation period 	ACTIONS <ul style="list-style-type: none"> Risk assessment Potential deferral of vaccination 15 minute observations period if vaccinated 	ACTIONS <ul style="list-style-type: none"> N/A
	ALLERGIES <ul style="list-style-type: none"> History of food, pet, insect, venom, environmental, latex, or other allergies not related to vaccines or injectable therapies History of allergy to oral medications (including the oral equivalent of an injectable medication) Non-serious allergy to vaccines or other injectables (e.g., no anaphylaxis) Family history of anaphylaxis Any other history of anaphylaxis that is not related to a vaccine or injectable therapy 	ALLERGIES <ul style="list-style-type: none"> History of severe allergic reaction (e.g., anaphylaxis) to another vaccine (not including either the Pfizer-BioNTech or the Moderna vaccine) History of severe allergic reaction (e.g., anaphylaxis) to an infectable therapy 	ALLERGIES <ul style="list-style-type: none"> History of severe allergic reaction (e.g., anaphylaxis) to any component of either the Pfizer-BioNTech or the Moderna vaccine
ALLERGIES	ACTIONS <ul style="list-style-type: none"> 30 minute observation period: Persons with a history of severe allergic reaction (e.g., anaphylaxis) due to any cause 15 minute observation period: Persons with allergic reaction, but not anaphylaxis 	ACTIONS <ul style="list-style-type: none"> Risk assessment Potential deferral of vaccination 30 minute observation period if vaccinated 	ACTIONS <ul style="list-style-type: none"> DO NOT VACCINATE

Regarding "Yes" answer to Question 7-Recent illness or antibody therapy. Vaccination should be deferred for 90 days as the circulating antibodies may interfere with vaccine response.

NOTES:
