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.

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***

For Office Use Only

Vaccine: COVID-19 **Route:** _____ **Dose:** _____
Manufacturer: _____
Lot Number: _____
Expiration Date: _____

EUA Date: _____ **Site:** Deltoid ☐ *Left* ☐*Right*
Administered By: _____
Date Given: _____ **Time Given:**_____
WEBIZ:_____ **SCANNED:** _____ **BILLED:**_____