Northern Valley Indian Health

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PATIENT SCREENING QUESTIONNAIRE AND CONSENT FOR COVID-19 VACCINE

Patient's Full Name (First, MI, Last): _____

Date of Birth:_____ Age:_____ Gender (circle one): Male / Female / Other_____

Street Address:_____ City:_____

State:_____ Zip Code:_____ Phone:_____

Primary Care Doctor:_____ Doctor's Number: _____

Emergency Contact Name and Number: _____

Emergency Contact Person's Relationship: _____

Which dose are you receiving today?

COVID-19 Dose		**COVID-19 Vaccine Manufacturer**		**If 2nd/3rd/Booster dose, enter date and facility of previous dose:**
☐	1st Dose	☐	Moderna	Date:
☐	2nd Dose	☐	Pfizer	
☐	3rd Dose	☐	Johnson & Johnson	Facility:
☐	Booster	☐	Other:	

Screening Questionnaire for Vaccination (if you answer yes, please explain below). Please circle:

1. Are you sick today?	Yes	No
2. Have you received any vaccination in the past two weeks?	Yes	No
3. Have you received passive antibody therapy as treatment for COVID-19	Yes	No
4. Have you ever received a dose of COVID-19 vaccine? If YES, which vaccine product? ☐ Pfizer ☐ Johnson & Johnson ☐ Moderna ☐ Other: _____	Yes	No
5. Have you ever had an allergic reaction to a previous dose of COVID-19 vaccine or components such as Polyethylene Glycol or Polysorbate?	Yes	No
6. Do you have allergies to medications, food, latex, or any vaccine components?	Yes	No
7. Have you ever had a serious reaction after receiving a vaccination or other injectable medication? • If YES to 7 above, was the serious allergic reaction after receiving a COVID-19 vaccine? • If YES to 7 above, was the serious allergic reaction after receiving another vaccine or other injectable medication?	Yes Yes Yes	No No No

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8. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	Yes	No
9. Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No
10. Do you have cancer, leukemia, AIDS, or any other immune system problem?	Yes	No
11. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	Yes	No
12. Have you had a seizure or a brain or other nervous system problem?	Yes	No
13. 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
14. Do you have dermal fillers?	Yes	No
15. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No
16. For women: Are you breastfeeding?	Yes	No

Consent and Waiver: I consent the staff to administer the vaccination mentioned above. I have reviewed the vaccine information provided to me, including the Emergency Use Authorization (EUA) Fact Sheet (available online at https://www.fda.gov/media/144414/download and understand the benefits and risks of receiving this vaccination and choose to assume this risk. I fully release and discharge the vaccination providers and Northern Valley Indian Health, its affiliations and their officers, and employees from any illness, injury, loss, or damage that may result therefrom. I assign payment of authorized insurance benefits due to me to be paid to the Northern Valley Indian Health. I consent to the release of medical information when necessary for billing, reimbursement, and medical protocol. I understand that Northern Valley Indian Health will report any vaccine medications I received to the appropriate state or federal Immunization Information System (IIS), Vaccine Administration Management System (VAMS) and/or other designated vaccine registry. I agree to wait near the vaccination area as designated by NVIH for approximately 15-30 minutes to receive care in case of adverse reaction.

I acknowledge that I have received a copy of the Notice of Privacy Policies of Northern Valley Indian Health. I understand the Notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed and of my rights with respect to my health information.

Patient/Parent/Legal Guardian:

_____/_____/_____

(Print name) (Signature) (Date)

Patient Name:_____DOB: _____

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This section for OFFICE USE ONLY- **To be completed by HEALTHCARE PROFESSIONAL administering vaccine*** ***(optional if documented directly into patient's electronic health record).**	
COVID Vaccine dose: ☐ **1st dose** ☐ **2nd dose** ☐ **3rd dose** ☐ **Booster dose**	**COVID-19 Vaccine Prevaccination Checklist Complete?** ☐ **Yes** ☐ **No**
Date COVID-19 vaccine administered:	**Facility/Location:**
COVID-19 Vaccine Prevaccination Checklist and administration deemedappropriate: ☐ **Yes** ☐ **No**	
☐ **Moderna 18 years and older**	☐ 1st dose **0.5mL** ☐ 2nd dose **0.5mL** ☐ 3rd dose for immunocompromised individuals **0.5mL** ☐ Booster dose for **18 years** and older **0.25 mL**
☐ **Pfizer 12 years and older**	☐ 1st dose **0.3mL** ☐ 2nd dose **0.3mL** ☐ 3rd dose for immunocompromised individuals **0.3mL** ☐ Booster dose for **12 years** and older **0.3mL**
☐ **Pfizer: Pediatric (5 to <12 years)**	☐ 1st dose **0.2mL** ☐ 2nd dose **0.2 mL**
☐ **Janssen: 18 years and older**	☐ 1st dose **0.5mL** ☐ Booster dose **0.5mL**

Lot Number:	**Expiration:**	**Administration time:**	**Date of VIS or EUA Fact Sheet:**

Immunization site:	☐ **Right Deltoid** ☐ **Left Deltoid**	☐ **Left Thigh (peds)** ☐ **Right Thigh (peds)**
☐ **Documentation complete in patient's electronic health record**		

_____ _____

Signature and Title of Vaccinator **Date**

Patient Name:_____DOB: _____