



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 2 nd /3 rd /Booster dose, enter date and facility of previous dose: |
|----------------------|-------------------------------|----------------------------------------------------------------------------------------------|
| 1 st Dose | Moderna | Date: _____ Facility: _____ |
| 2 nd Dose | Pfizer | |
| 3 rd Dose | Johnson & Johnson | |
| 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? <input type="checkbox"/> Pfizer <input type="checkbox"/> Johnson & Johnson <input type="checkbox"/> Moderna <input type="checkbox"/> 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? <ul style="list-style-type: none">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 | 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: <input type="checkbox"/> 1 st dose <input type="checkbox"/> 2 nd dose <input type="checkbox"/> 3 rd dose <input type="checkbox"/> Booster dose | | COVID-19 Vaccine Prevaccination Checklist Complete? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Date COVID-19 vaccine administered: | | Facility/Location: | |
| COVID-19 Vaccine Prevaccination Checklist and administration deemed appropriate: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| <input type="checkbox"/> Moderna 18 years and older | <input type="checkbox"/> 1 st dose 0.5mL <input type="checkbox"/> 2 nd dose 0.5mL | <input type="checkbox"/> 3 rd dose for immunocompromised individuals 0.5mL <input type="checkbox"/> Booster dose for 18 years and older <u>0.25 mL</u> | |
| <input type="checkbox"/> Pfizer 12 years and older | <input type="checkbox"/> 1 st dose 0.3mL <input type="checkbox"/> 2 nd dose 0.3mL | <input type="checkbox"/> 3 rd dose for immunocompromised individuals 0.3mL <input type="checkbox"/> Booster dose for 12 years and older 0.3mL | |
| <input type="checkbox"/> Pfizer: Pediatric (5 to <12 years) | | <input type="checkbox"/> 1 st dose 0.2mL | <input type="checkbox"/> 2 nd dose 0.2 mL |
| <input type="checkbox"/> Janssen: 18 years and older | | <input type="checkbox"/> 1 st dose 0.5mL | <input type="checkbox"/> Booster dose 0.5mL |
| Lot Number: | Expiration: | Administration time: | Date of VIS or EUA Fact Sheet: |
| Immunization site: | <input type="checkbox"/> Right Deltoid <input type="checkbox"/> Left Deltoid | <input type="checkbox"/> Left Thigh (peds) <input type="checkbox"/> Right Thigh (peds) | |
| <input type="checkbox"/> Documentation complete in patient's electronic health record | | | |

Signature and Title of Vaccinator _____

Date _____

Patient Name: _____ DOB: _____

