

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: _____

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 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
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

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

For Office Use Only

Vaccine: COVID-19

Route: _____ **Dose:** _____

Manufacturer: _____

EUA Date: _____

Lot Number: _____

Site: Deltoid *Left* *Right*

Expiration Date: _____

Administered By: _____ **Date Given:** _____
Signature and Title of Vaccine Administrator