

# COVID-19 Vaccine Documentation/Consent Form

## Patient Information (Please print legibly)

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle name:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Biological Sex:**  Female  Male  Unknown or Not Reported  
**Ethnicity:**  Non-Hispanic/Latino  Hispanic/Latino (Central/South America, Mexico, Cuba, Puerto Rico, Other)  Unknown/Not Reported  
**Race 1:**  White  Black or African American  Asian  American Indian or Alaska Native  
 Native Hawaiian or Other Pacific Islander  Other  Unknown or Not Reported  
**Race 2:**  White  Black or African American  Asian  American Indian or Alaska Native  
 Native Hawaiian or Other Pacific Islander  Other  Unknown or Not Reported  
**Race 3:**  White  Black or African American  Asian  American Indian or Alaska Native  
 Native Hawaiian or Other Pacific Islander  Other  Unknown or Not Reported  
**Residential Address:** \_\_\_\_\_ **City:** \_\_\_\_\_  
**State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **County:** \_\_\_\_\_  
**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
4. 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
13. Have you previously received a vaccination for COVID-19?  Yes  No
- a. If yes, which vaccine did you receive?  Pfizer  Moderna  Janssen/J&J
- b. If yes, what were approximate dates for: 1<sup>st</sup> Shot \_\_\_\_\_ 2<sup>nd</sup> Shot \_\_\_\_\_
14. Do you have a disability?  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

**If patient is a minor:**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent/Guardian

**For Office Use Only**

**Vaccine:** COVID-19 **Route:** Intramuscular **Dose:** \_\_\_ mL

**Manufacturer:**  Moderna  Pfizer  J&J  Other \_\_\_\_\_

**Lot Number:** \_\_\_\_\_

**Site:** Deltoid  Left  Right

**Expiration Date:** \_\_\_\_\_

Other \_\_\_\_\_

**Administered By:** \_\_\_\_\_

**Date Given:** \_\_\_\_\_

*Signature and Title of Vaccine Administrator*