**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/Refused

**Ethnicity:**   Non-Hispanic  Hispanic  Unknown/Refused   
**Race:**   White  Black or African American  Asian  American Indian or Alaska Native   
 Native Hawaiian/Pacific Islander  Other  Unknown/Refused

**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 *Yes* *No*

currently being monitored for COVID-19?

1. In the past two weeks, have you had contact with anyone who tested positive for COVID-19? *Yes* *No*
2. Do you currently or have you in the past two weeks had a fever, chills, cough, *Yes* *No*  
   shortness of breath, difficulty breathing, fatigue, muscle or body aches,   
   headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?

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, *Yes* *No*  
   liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes),   
   anemia or other blood disorder?
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. Do you have a disability? *Yes* *No*

Adults of any age with **certain underlying medical conditions** are at increased risk for severe illness from the virus that causes COVID-19. This list is not all-inclusive – there may be other conditions which increase one’s risk for developing severe illness from COVID-19.

* Asthma (moderate to severe)
* Cancer
* Cerebrovascular disease (affects blood vessels and blood supply to the brain)
* Chronic kidney disease
* COPD (Chronic Obstructive Pulmonary Disease)
* Cystic fibrosis
* Diabetes mellitus- type 1
* Diabetes mellitus- type 2
* Down Syndrome
* Heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
* Hypertension (high blood pressure)
* Immunocompromised state (weakened immune system) from solid organ transplant
* Immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune-weakening medicines
* Liver disease
* Neurologic conditions, such as dementia
* Obesity (body mass index [BMI] of 30 kg/m2 or higher but < 40 kg/m2) or Severe Obesity (BMI > 40 kg/m2)
* Overweight (BMI > 25 kg/m2, but < 30 kg/m2)
* Pregnancy
* Pulmonary fibrosis (having damaged or scarred lung tissues)
* Sickle cell disease
* Smoking
* Thalassemia (a type of blood disorder)

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| --- | --- |
| **Please check one box below:**  I attest that I have one of the conditions listed above.  I attest that I have a chronic health condition which places me at increased risk of severe illness if I get COVID-19.  I attest that I am the adult caregiver of a child <16 years of age with a chronic health condition that places the child at increased risk of severe illness if infected with COVID-19.  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. |  |

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*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:** 0.5mL

**Manufacturer:** Moderna **EUA Date:** 12/18/20  
**Lot Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Site:** Deltoid  *Left*  *Right*

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

**Administered By:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Given:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature and Title of Vaccine Administrator*