USD 259 COVID-19 VACCINE CLINIC QUESTIONNAIRE AND CONSENT FORM

DEMOGRAPHIC INFORMATION

Last Name: **First Name:** **Middle Initial:**

Parent if under 18: **Date of Birth:** **Age:** **Gender:** ☐ **Male** ☐ **Female**

Race: ☐ **African American** ☐ **Asian** ☐ **Native American** ☐ **Middle Easterner** ☐ **Pacific Islander** ☐ **White** ☐ **Other**

Hispanic: ☐ **Yes** ☐ **No** **Phone Number:** **Staff/Student ID Number:**

Street Address: **Email:**

City: **State:** **Zip:** **County:**

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you should/should not be vaccinated. It just means additional questions may be asked and you may need extra time allotted for post-vaccine monitoring. If you have questions or concerns, please address with your personal healthcare provider prior to coming to your COVID-19 vaccine appointment.

IMMUNIZATION SCREENING QUESTIONNAIRE	YES	NO
Are you experiencing moderate to severe illness and/or have a fever today?	☐	☐
Have you received a COVID-19 vaccine? If yes, which vaccine did you receive? ☐ **Moderna** ☐ **Pfizer** ☐ **J&J** **Date(s) Received - Dose 1:** **Dose 2:** **Booster:**	☐	☐
Do you have a weakened immune system? (i.e. cancer/cancer treatment, immunosuppressant drug therapy, immune system diseases, advanced or untreated HIV)	☐	☐
Have you ever had an allergic reaction to: • **A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures** • **Polysorbate** • **A previous dose of COVID-19 vaccine** (*This would include anaphylaxis or other severe reaction that required treatment with epinephrine or that caused you to go to the hospital, or a reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress/wheezing.) **If yes, it is not recommend that you receive this vaccine***	☐	☐
Have you ever had an allergic reaction to another vaccine (other than COVID-19) or an injectable medication? *(This would include anaphylaxis or other severe reaction that required treatment with epinephrine or that caused you to go to the hospital, or a reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress/wheezing.)*; OR **Have you ever had a severe allergic reaction (i.e. anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication?** *This would include pet, food, environmental, or oral medication allergies.*	☐	☐
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 within the last 90 days? *If yes, you will need to reschedule your appointment time.*	☐	☐
Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐

COVID-19 VACCINE CONSENT – Please print and sign/date in the area below. BRING THE PRINTED COPY TO YOUR VACCINE APPOINTMENT.

I hereby authorize the USD 259 COVID-19 vaccine clinic to share this information with public health entities at the local, state and federal level for purposes of ensuring medication efficacy and safety. I also authorize the USD 259 COVID-19 vaccine clinic to share this information with USD 259 HS/ HR/EBIM departments. By signing below, I acknowledge that I have been offered a copy of the Emergency Use Authorization Fact Sheets (linked HERE) and I consent for the COVID-19 vaccine to be given to me. ***Following the administration of the vaccine, I agree that I will seek medical advice, care and treatment from my usual source of health care if I have questions or concerns, have any symptoms of illness, or become ill, and that I will call 911 in the event of an emergency.***

Signature: Date: Relationship: Self ☐ Parent/Guardian ☐

CLINICIAN USE ONLY - DO NOT COMPLETE THIS SECTION

VACCINE/LOT#/EXP DATE	DOSE
	☐ **1st Dose** ☐ **2nd Dose** ☐ **3rd Dose** ☐ **1st Booster** ☐ **2nd Booster** ☐ **Other**

DATE	TIME	EXT	SITE	ROUTE
		☐ Left ☐ Right	☐ Vastus Lateralis ☐ Deltoid	IM

Date:

Signature and Title of Vaccine Administrator:

OBSERVATION TIME

☐ **15 MINUTES** ☐ **30 MINUTES**

If visitor lot is fulll, park in staff lot along Lincoln

Enter through Door 33.

Park in Visitor Parking.