

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: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Race: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Middle Easterner <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other		Hispanic: Yes No		Phone Number: Staff/Student ID Number:		
Street Address:		Email:		City: State: Zip: County:		
<p><i>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.</i></p>						
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:						
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: <ul style="list-style-type: none"> • 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. <i>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.</i>						
Signature:		Date:		Relationship: Self	Parent/Guardian	
CLINICIAN USE ONLY - DO NOT COMPLETE THIS SECTION						
VACCINE		LOT #	EXP DATE	DOSE		
Moderna COVID-19 Vaccine, 50mcg/0.25ml		002M21A	07/11/2022	Booster Dose		
Moderna COVID-19 Vaccine, 100mcg/0.5ml		002M21A	07/11/2022	1st Dose	2nd Dose 3rd Dose	
Pfizer COVID-19 Vaccine, 30mcg/0.3ml (12+)			.	1st Dose	2nd Dose Booster Dose	
Pfizer COVID-19 Vaccine, 10mcg/0.2ml (5-11)			.	1st Dose	2nd Dose	
DATE	TIME	EXT		SITE		ROUTE
		Left	Right	Vastus Lateralis	Deltoid	IM
Signature and Title of Vaccine Administrator:				Date:		
OBSERVATION TIME						
15 MINUTES		30 MINUTES				

