San Luis Valley HEALTH

COVID-19 Vaccine Screening Checklist/Administration/Consent Record

2020-2021 Dose 1

PLEASE PRINT

LAST FIRST INITIAL BIRTHDATE AGE

ADDRESS CITY STATE ZIP

PHONE NUMBER EMAIL ADDRESS

RACE:
a. American Indian/Alaska Native b. Asian
c. Black/African American d. Native Hawaiian or Pacific Islander
e. White f. Other: _____ g. Refused

ETHNICITY:
a. Hispanic
b. Non-Hispanic
c. Refused

Question:	Yes	No	I don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product did you receive? __ Pfizer __ Moderna __ Another product: _____			
3. Have you ever had an allergic reaction* to: a. 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 b. Polysorbate c. A previous dose of COVID-19 vaccine *This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.			
4. Have you ever had an allergic reaction* to another vaccine (other than COVID-19 vaccine) or an injectable medication? This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have any questions or concerns that you'd like to speak with a nurse, provider, or pharmacist about?			

Consent Record

"I have read or have had explained to me the information about the COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand that the COVID-19 vaccine has been authorized by the FDA for emergency use and has not been FDA approved. I have received the information that is available at this time and I ask that the vaccine be given to me."

SLV Health will keep this record. SLV Health will record what vaccine was given,when the vaccine was given, the vaccine brand, the lot number, site of administration an d the signature and title of the person who gave the vaccine.

X_____DATE:_____

Signature of person to receive vaccine/Parent or Guardian

xxxxxxxxxxxxxxxxxxxxxxxxx FOR OFFICE USE ONLY xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

SAN LUIS VALLEY HEALTH, 106 BLANCA AVE, ALAMOSA, CO 81101

DATE VACCINE ADMINISTERED: _____ MANUFACTURER: Pfizer Moderna

Lot Number: _____ EXP. DATE: _____ SITE: R Deltoid L Deltoid

SIGNATURE OF VACCINE ADMINISTRATOR: _____

Documented in CIIS: YES NO Information given to patient: YES NO