COVID-19 Vaccine Pre-Screening Form

Last Name (please print):	First Name:	Middle Initial:	Sex (Mark one): ☐ Male ☐ Female
Home Address:	**City:**	**State:**	**Zip:**
Email:	**Phone number:**	**Date of Birth:**	**Age:**
***Parent/Guardian/ Surrogate (if applicable, please print):**	*If applicable, by signing this form, I am attesting I am the parent/legal guardian of said minor to receive the COVID 19 vaccine.		

Screening Questionnaire			
1.	Are you feeling sick today?	☐ Yes	☐ No
2.	Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ☐ Another product	☐ Yes	☐ No
3.	Have you ever had a severe allergic reaction to something, or a reaction that you were treated with Epinephrine or EpiPen, or for which you had to go to the hospital? If yes, what is the allergy?	☐ Yes	☐ No
4.	Do any of the following apply to you? If yes, please check all that apply: ☐ Have a history of myocarditis or pericarditis ☐ Have a history of heparin-induced thrombocytopenia (HIT) ☐ Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19	☐ Yes	☐ No

Consent: I have read and understand or had explained to me the information sheet about the COVID-19 vaccination. I have made the decision to receive the COVID-19 vaccine voluntarily and freely. I know I have the option to refuse this vaccine. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses of this vaccine in order for it to be effective. I have had a chance to ask questions which were answered to my satisfaction or ensured that the person receiving the vaccine above for whom I am authorized to provide surrogate consent was also given a chance to ask questions. I understand the benefits and risks of the vaccination as described. I request that the COVID-19 vaccination to be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand that with all vaccines there is no promise that I will become immune or that I will not have side effects.

Disclosure of Records: I understand the organization providing my vaccine may be required to or may voluntarily disclose my vaccine-related health information to my primary care physician, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, or health care operations. I also understand the organization providing my vaccine will use and disclose my health information as described in its Notice of Privacy Practices, which I may receive upon request.

Signature (Patient or Legal Representative):	**Date:**

For Administrative Use Only

PEDIATRIC DOSE, 5-11 YEARS OF AGE

Manufacturer	Vaccine	Dose	Route	Expiration Date	Dose in Series	Site	Lot#	Date of VIS	Date Given
Pfizer	COVID-19	0.2 mL	IM		1 2	Deltoid- Left Right Other:		English: 10/29/2021 Spanish: 10/29/2021	

ADULT DOSE, 12 YEARS OF AGE AND OLDER

Manufacturer	Vaccine	Dose	Route	Expiration Date	Dose in Series	Site	Lot#	Date of VIS	Date Given
Pfizer	COVID-19	0.3 mL	IM		1 2 B	Deltoid- Left Right Other:		English: 12/09/2021 Spanish: 10/29/2021	

ADULT DOSE, 18 YEARS OF AGE AND OLDER

Manufacturer	Vaccine	Dose	Route	Expiration Date	Dose in Series	Site	Lot#	Date of VIS	Date Given
Moderna	COVID-19	0.5 mL 0.25 mL	IM		1 2 B	Deltoid- Left Right Other:		English: 12/09/2021 Spanish: 10/20/2021	
Janssen (J&J)	COVID-19	0.5 mL	IM		1 B	Deltoid- Left Right Other:		English: 11/19/2021 Spanish: 10/29/2021	

Vaccinator Signature and credentials: _____