

Patient Name, Last: _____ First: _____ Middle: _____

Preferred Name: _____ Pronouns: _____

Date of Birth: _____ Age: _____ Gender: Male Female _____ Declined

Home or Mailing- Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____ Phone Number: () _____

Has your address changed in the last 5 years? If so, list previous street name(s): _____

Email address: _____ Language preference: _____

A. GENERAL Vaccine Screening Questions		Circle one:		
1. Do you have a fever or feel sick today?	Yes	No		
2. In the last 10 days, have you tested positive for COVID-19?	Yes	No		
3. Have you ever had a severe allergic reaction (i.e. Anaphylaxis or hives/swelling/difficulty breathing) to something that required treatment with epinephrine or EpiPen®, or for which you had to go to the hospital? This includes another vaccine, injectable or oral medication, food, pet, bee sting, etc...?	Yes	No	Unknown	
4. Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	Yes	No	Unknown	
5. Are you moderately to severely immunocompromised? (i.e. Chemotherapy, organ transplant, immunosuppressive drugs, high-dose corticosteroids, HIV infection)	Yes	No	Unknown	
6. Have you ever fainted after an injection or blood draw?	Yes	No		
7. Do you have health insurance? • If yes , is it: <input type="checkbox"/> Private (<i>employer provided, family/spouse provided, or otherwise paid for privately</i>) <input type="checkbox"/> OHP/Medicaid (<i>Provided for free by the state of Oregon, i.e. Health Share, Trillium, PacificSource</i>)	Yes	No	Unknown	
B. COVID-19 Vaccine Screening Questions		Circle one:		
1. Have you ever received a dose of COVID-19 vaccine? • If yes , select <u>all</u> that apply: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Novavax <input type="checkbox"/> Janssen/J&J <input type="checkbox"/> Other: _____	Yes	No	Unknown	
2. Have you ever had an immediate allergic reaction or anaphylaxis to any of the following: • A previous dose of the COVID-19 vaccine, or any ingredients of the vaccine? • Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures? • Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids?	Yes Yes Yes	No No No	Unknown Unknown Unknown	
C. FLU Vaccine Screening Questions		Circle one:		
1. Is today's flu shot your first flu vaccine ever? (For under 8 years old only. If yes, will need a booster dose after 28 days)	Yes	No	Unknown	
2. Have you ever had Guillain-Barré Syndrome within 6 weeks after receiving a flu vaccine?	Yes	No	Unknown	

Patient/Legal Guardian Consent

I have received, read and had my questions answered about the Emergency Use Authorization/Vaccine Information Fact Sheet. I understand the risks and benefits involved in receiving this vaccine. I consent to the vaccine being given to me or the person named above for whom I have the legal authority to consent. I consent to the release of any information needed to process insurance claims and/or request payments of medical benefits.

Print name: _____

Signature: _____

Date: _____

If not patient, relationship to patient: _____

If signing on behalf of a minor 14 years of age or younger receiving a vaccine, please read and initial below:

- _____ I have the legal authority to consent on behalf of the child/minor named above to vaccination.
- _____ I attest that the person receiving the vaccine is six months of age or older, and that the birthdate and age stated above are correct.
- _____ I understand that I am not required to accompany the child/minor named above to their vaccination appointment and that, by giving my consent; the child/minor will receive an influenza, Pfizer, Moderna or Novavax vaccine whether or not I am present at the vaccination appointment. If I am not present, an adult over 18 will accompany my child.

FOR CLINIC USE ONLY

Dose	Vaccine	Brand/Mfr, Age Group, Lot #, Expiration, Dose (mL), Fact Sheet/VIS Publication Date	Site/Route	Eligibility Code (circle)
Little Peds (6m-4y) Primary Series ONLY: PFIZER: 1 2 3 MODERNA: 1 2	COVID-19			VFC: N M A F <small>(6 mo – 18 yrs)</small> Uninsured <small>(19+ yrs)</small>
N/A <small>Reminder: If this is the first dose ever received & under 8 years old, advise that a second dose is recommended after 28 days.</small>	FLU			VFC: N M A F <small>(6 mo – 18 yrs)</small> Local <small>(HD 65+ yrs)</small> Special <small>"Vulnerable" (18-64 yrs)</small>

Vaccine Administrator Signature: _____ **Title:** _____ **Date:** _____

MRN: _____

Vaccine site/route codes:

L/R DIM= Left/Right Deltoid Intramuscular
L/R VLIM= Left/Right Vastus Lateralis Intramuscular

VFC Coding:

No Insurance
Medicaid (OHP)
Alaska Native / American Indian
F Underinsured

Time to Leave: _____ am / pm

Circle: 15 min or 30 min observation