



# Colorado COVID-19 Vaccine Screening and Administration Form



Please print neatly in capital letters as shown in the example: <div style="border: 1px solid black; padding: 2px; display: inline-block; font-family: monospace; font-size: 1.2em;">           E X A M P L E    1 2 3         </div>	Please answer all questions as completely as possible. Please use only <b>black</b> ink to complete form.	The administration record is on the reverse side of this document.
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Please complete ALL the information below as accurately as possible. If you are completing this form for your minor child, do not use nick-names or abbreviations, except where allowed. All information will be kept confidential.

Patient/Child Last Name	Patient/Child First Name	M.I.

Date of Birth	Age (years)	Age (months)	Patient/Representative Daytime Phone Number																											
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="font-size: 0.8em; text-align: center;">M</td> <td style="font-size: 0.8em; text-align: center;">M</td> <td style="font-size: 0.8em; text-align: center;">D</td> <td style="font-size: 0.8em; text-align: center;">D</td> <td style="font-size: 0.8em; text-align: center;">Y</td> <td style="font-size: 0.8em; text-align: center;">Y</td> <td style="font-size: 0.8em; text-align: center;">Y</td> <td style="font-size: 0.8em; text-align: center;">Y</td> </tr> </table>									M	M	D	D	Y	Y	Y	Y	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>					<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>								
M	M	D	D	Y	Y	Y	Y																							

If under 18 years of age please complete Parent First Name	Parent Last Name

Address	Apt. Number

City	County	State

Zip Code	E-mail Address

Gender Identity  F  M  Transgender Female/Feminine  Transgender Male/Masculine  Non-Binary  Un-specified  Decline to Provide

Are you Hispanic/Latin/a/o/x? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Provide	Race(s) check all that apply <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black, African American <input type="checkbox"/> Other <input type="checkbox"/> Decline to Provide <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White
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Health Insurance (OPTIONAL-INSURANCE NOT REQUIRED FOR VACCINATION) Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Kaiser Permanente <input type="checkbox"/> United Healthcare <input type="checkbox"/> Other Private <input type="checkbox"/> No Insurance <input type="checkbox"/>	Insurance Policy Number

If you have already received your Primary Dose(s) of a COVID-19 vaccine, please tell us which vaccine(s) you received and the date(s) of vaccination.

Dose(s) received: Dose 1: Vaccine Brand \_\_\_\_\_ Vaccination Date \_\_\_\_/\_\_\_\_/\_\_\_\_ | Dose 2: Vaccine Brand \_\_\_\_\_ Vaccination Date \_\_\_\_/\_\_\_\_/\_\_\_\_

If you have already received more than two (2) doses of a COVID-19 vaccine, please tell us which additional dose(s) you received, the vaccine(s), and the date(s) of vaccination.

Additional Dose received for High Risk Conditions : Vaccine Brand \_\_\_\_\_ Vaccination Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Booster Dose: Vaccine Brand \_\_\_\_\_ Vaccination Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Additional Booster Dose: Vaccine Brand \_\_\_\_\_ Vaccination Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Health Screening Questions	Yes	No	Don't Know
1. Are you or your child sick today or have a fever?			
2. Have you or your child had an allergic reaction to polysorbate, polyethylene glycol, or a previous dose of COVID-19 vaccine?			
3. Have you or your child ever had a serious allergic reaction (anaphylaxis) to another vaccine or any injectable medication?			
4. Have you or your child had severe allergic reaction (anaphylaxis) to foods, pets, venom, environmental or oral medications?			
5. Do you or your child have a bleeding disorder, are on long-term aspirin therapy, or take other blood thinners?			
6. Have you or your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) after receiving a vaccine?			
7. Have you received any dermal fillers (Juvaderm®, Restylane®, etc.)? (only applies to mRNA vaccines)			
8. Do you have a history of blood clots or have risk factors for developing blood clots? (Janssen vaccine only, applies to females ages 18-49)			
9. Do you or your child have a history of myocarditis or pericarditis? (Especially males ages 12-29 years after receiving a dose of mRNA vaccine)			
10. Do you or your child have a history of heparin-induced thrombocytopenia (HIT)?			
11. Do you or your child have a history of Multisystem Inflammatory Syndrome known as MIS-C (in children) or MIS-A (in adults) after a COVID-19 infection?			
12. Are you or your child immunocompromised? (See additional dose section on next page)			

Patient/Child Last Name										Patient/Child First Name										M.I.	
Date of Birth		/		/						Age (years)		Age (months)		Primary Dose : 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		Booster Dose: 1 <input type="checkbox"/> 2* <input type="checkbox"/>					

**Authorization to Administer COVID-19 Vaccine**

I have read or had explained to me the Fact Sheet for Recipients and Caregivers for the use of the COVID-19 vaccine and understand the benefits and risks to me or my child of receiving this vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I hereby release this provider, its employees and its volunteers from any liability for any results which may occur from the administration of this vaccine.

Signature of Patient/Parent/Legal Guardian/  
Medical Durable Power of Attorney: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**STOP: DO NOT WRITE BELOW THIS LINE-FOR CLINIC STAFF ONLY**

COVID/VFC PIN				Provider Type <input type="checkbox"/> Public <input type="checkbox"/> Private		Clinic Name				Provider Name					
Brand Name						Primary Dose		Booster Dose		Site		Date Administered			
						<b>Pfizer (Purple or Gray Cap)</b> Adult dose <input type="checkbox"/> 0.3 ml Moderna <input type="checkbox"/> 0.5 ml J&J <input type="checkbox"/> 0.5 ml		<input type="checkbox"/> 0.3 ml Pfizer <input type="checkbox"/> 0.25 ml Moderna <input type="checkbox"/> 0.5 ml J&J		<input type="checkbox"/> LD <input type="checkbox"/> LT <input type="checkbox"/> RD <input type="checkbox"/> RT					
Lot Number						<b>Pfizer (Orange Cap) Pediatric Dose</b> (age 5-11 y.o.) <input type="checkbox"/> 0.2 ml				Administered by:					
										Name _____ Title _____					

For vaccine administration guidance, including: timing, dosing, site selection, needle length and gauge, and administration procedures, please reference your standing orders or the CDC’s Interim Clinical Considerations”.

<https://covid19.colorado.gov/vaccine-providers>

<https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html>

<https://www.immunize.org/covid-19/>

\*Additional guidance from the FDA for 2<sup>nd</sup> booster dose is as follows:

- A second booster dose of either the **Pfizer-BioNTech COVID-19 Vaccine** or **Moderna COVID-19 Vaccine** may be administered to **individuals 50 years of age and older** at least 4 months after receipt of a first booster dose of any authorized or approved COVID-19 vaccine.
- A second booster dose of the **Pfizer-BioNTech COVID-19 Vaccine** may be administered to **individuals 12 years of age and older** with certain kinds of immunocompromise at least 4 months after receipt of a first booster dose of any authorized or approved COVID-19 vaccine. These are people who have undergone solid organ transplantation, or who are living with conditions that are considered to have an equivalent level of immunocompromise.
- A second booster dose of the **Moderna COVID-19 Vaccine** may be administered at least 4 months after the first booster dose of any authorized or approved COVID-19 vaccine to **individuals 18 years of age and older** with the same certain kinds of immunocompromise.