Colorado COVID-19
Vaccine Screening and Administration Form

Please print neatly in capital letters as shown in the example:

E	X	A	M	P	L	E		1	2	3

Please answer all questions as completely as possible.
*Please use only **black** ink to complete form.*

The administration record is on the reverse side of this document.

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.

Last Name **First Name** **M.I.**

Date of Birth (M M / D D / Y Y Y Y) **Age (years)**

Patient/Representative Daytime Phone Number ( ) - ( ) -

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?
☐ Yes ☐ No
☐ Decline to Provide

Race(s) check all that apply
☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Decline to Provide
☐ Asian ☐ Other
☐ Black, African American ☐ White

Health Insurance **(OPTIONAL-INSURANCE NOT REQUIRED FOR VACCINATION)**
☐ Medicaid ☐ Medicare ☐ Kaiser Permanente ☐ Other Private ☐ No Insurance

Insurance Policy Number

If you have already been vaccinated with a COVID-19 vaccine, please tell us which vaccine(s) was received, the number of doses, and the date(s) of vaccination.
Dose(s) received: Dose 1: Vaccine Brand_____ **Vaccination Date** _____/_____/_____ **| Dose 2: 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 or your child had convalescent plasma or monoclonal antibodies as part of COVID-19 treatment in the past 3 months?			
8.	Have you received any dermal fillers (Juvaderm®, Restylane®, etc.)? (only applies to mRNA vaccines)			
9.	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)			
10.	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)			
11.	Do you or your child have a history of heparin-induced thrombocytopenia (HIT)?			
12.	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?			
13.	Are you or your child immunocompromised? (See additional dose section on next page)			
14.	Do you have an underlying medical condition that puts you at high risk for severe COVID-19? (Applies to adults 18-64) (See booster dose section)			
15.	Are you at increased risk for COVID-19 because of where you work or live? (Applies to adults age 18-64) (See booster dose section)			

Continued on Next Page

Last Name | **First Name**

Date of Birth M M / D D / Y Y Y Y

Dose Number: 1 ☐ 2 ☐ 3 ☐

Authorization to Administer COVID-19 Vaccine

I have read or had explained to me the Emergency Use Authorization 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	Clinic Name	Provider Name
0730	☐ Public ☒ Private	Highlands Integrative Pediatrics	

Manufacturer	Lot Number	Dosage	Site	Date Administered
☒ PFR (Pfizer) ☐ AstraZeneca ☐ Moderna ☐ Novavax ☐ Janssen		☐ 0.3 ml ☐ 0.5 ml	☐ LD ☐ LT ☐ RD ☐ RT	M M / D D / Y Y Y Y

Administered by:

Name _____ Title _____

ADDITIONAL DOSE INFORMATION

- Currently, CDC is recommending that **moderately to severely immunocompromised** people receive an additional dose. **Applies to: Pfizer vaccine - age 12 and over; Moderna vaccine - ages 18 and over at this time. Effective 8/13/2021 for those who have:**
  - Been receiving active cancer treatment for tumors or cancers of the blood
  - Received an organ transplant and are taking medicine to suppress the immune system
  - Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
  - Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
  - Advanced or untreated HIV infection
  - Active treatment with high-dose corticosteroids or other drugs that may suppress immune response ((i.e., ≥20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory).
- The additional mRNA COVID-19 vaccine dose *should be the same vaccine product as the initial 2-dose mRNA COVID-19 primary vaccine series* (Pfizer-BioNTech or Moderna).
- If the mRNA COVID-19 vaccine product given for the first two doses is not available, the other mRNA COVID-19 vaccine product may be administered. A person should not receive more than three mRNA COVID-19 vaccine doses.
- Until additional data are available, the additional dose of an mRNA COVID-19 vaccine should be administered at least 28 days after completion of the initial 2-dose mRNA COVID-19 vaccine series, based on expert opinion.
- Currently there are insufficient data to support the use of an additional mRNA COVID-19 vaccine dose after a single-dose Janssen COVID-19 vaccination series in immunocompromised people. FDA and CDC are actively working to provide guidance on this issue.

BOOSTER DOSE INFORMATION

- Currently, CDC is recommending that the following people receive a booster dose at least 6 months after completion of Pfizer primary series. **Applies to Pfizer ONLY. Effective 9/24/21 for:**
  - people 65 years and older and residents in long-term care settings should receive a booster shot of Pfizer-BioNTech's COVID-19 vaccine at least 6 months after their Pfizer-BioNTech primary series,
  - people aged 50–64 years with underlying medical conditions should receive a booster shot of Pfizer-BioNTech's COVID-19 vaccine at least 6 months after their Pfizer-BioNTech primary series,
  - people aged 18–49 years with underlying medical conditions may receive a booster shot of Pfizer-BioNTech's COVID-19 vaccine at least 6 months after their Pfizer-BioNTech primary series, based on their individual benefits and risks, and
  - people aged 18-64 years who are at increased risk for COVID-19 exposure and transmission because of occupational or institutional setting may receive a booster shot of Pfizer-BioNTech's COVID-19 vaccine at least 6 months after their Pfizer-BioNTech primary series, based on their individual benefits and risks.