

# COVID-19 Vaccine Documentation/Consent Form

## Patient Information (Please print legibly)

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Biological Sex:** ☐ Female ☐ Male ☐ Unknown or Not Reported

**Ethnicity:** ☐ Non-Hispanic/Latino ☐ Hispanic/Latino (Central/South America, Mexico, Cuba, Puerto Rico, Other) ☐ Unknown/Not Reported

**Race 1:** ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native  
☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown or Not Reported

**Race 2:** ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native  
☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown or Not Reported

**Race 3:** ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native  
☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown or Not Reported

**Residential Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **County:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

## Screening Questionnaire

### COVID-19 Screening Questions

1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19? ☐ Yes ☐ No
2. In the past two weeks, have you had contact with anyone who tested positive for COVID-19? ☐ Yes ☐ No
3. Do you currently or have you in the past two weeks had a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea? ☐ Yes ☐ No
4. Patient temperature: \_\_\_\_\_ Date: \_\_\_\_\_

### Immunization Screening Questions

1. Are you sick today (cold, fever, acute illness)? ☐ Yes ☐ No
2. Do you have any allergies to medications, food, a vaccine or latex? ☐ Yes ☐ No
3. Have you had a serious reaction to a vaccine in the past? ☐ Yes ☐ No
4. Have you ever had Guillain-Barre syndrome? ☐ Yes ☐ No
5. Are you pregnant or is there a chance you could become pregnant in the next month? ☐ Yes ☐ No
6. Are you currently breastfeeding? ☐ Yes ☐ No
7. Do you have a blood-clotting disorder or are currently taking blood thinners? ☐ Yes ☐ No
8. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder? ☐ Yes ☐ No
9. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease or other condition that makes it hard for you to fight infections? ☐ Yes ☐ No
10. Do you have a weakened immune system or in the past 3 months, taken medications that weaken it such as cortisone, prednisone, other steroids, anti- cancer drugs or radiation treatments? ☐ Yes ☐ No

11. During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?

☐ Yes ☐ No

12. In the past 4 weeks, have you received any vaccinations or a TB skin test?

☐ Yes ☐ No

13. Do you have a disability?

☐ Yes ☐ No

I have been offered a copy of the COVID-19 Emergency Use Authorization (EUA). I have read, had explained to me, and understand the information in the EUA. I ask that the vaccine be administered to me. I consent to inclusion of this immunization data in the Kansas Immunization Information System (KSWebIZ) for myself.

\_\_\_\_\_  
*Signature of Patient*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name of Patient*

\_\_\_\_\_  
*Date of Birth*

**If patient is a minor:**

\_\_\_\_\_  
*Signature of Parent/Guardian*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name of Parent/Guardian*

### For Office Use Only

**Vaccine:** COVID-19

**Route:** Intramuscular **Dose:** \_\_\_\_ mL

**Manufacturer:** ☐ Moderna ☐ Pfizer ☐ J&J ☐ Other \_\_\_\_\_

**Lot Number:** \_\_\_\_\_

**Site:** Deltoid ☐ Left ☐ Right

**Expiration Date:** \_\_\_\_\_

☐ Other \_\_\_\_\_

**Administered By:** \_\_\_\_\_  
*Signature and Title of Vaccine Administrator*

**Date Given:** \_\_\_\_\_