WELCOME TO THE CHEYENNE VA VACCINE CLINIC

Name:(Last)	**(First)**	**Last 4:**
Date of Birth: / /	**Age:**	**Phone Number:**
Occupation: _____ or are you considered an essential worker? Yes / No		

You are here today to receive:	**Yes**	**No**
COVID Vaccine		
FLU Vaccine: **If only receiving flu vaccine today, move to signing consent at bottom of sheet**		

Please mark which Vaccine you have had and what was your dose number and Date:		
Pfizer	1 dose 2 dose 3 dose	Date of last dose:
Moderna	1 dose 2 dose 3 dose	Date of last dose:
Janssen (Johnson & Johnson) ***If patient received Janssen 1st dose, no additional criteria are required if received dose 2 months or more prior – can receive any product**	1 dose 2 dose	Date of last dose:
Other:		Date of last dose:

Do you have?	**Yes**	**No**
Cancer (active) or are being treated with chemotherapy or radiation or an autoimmune disease		
Other disease or take medication that makes you immunocompromised:		
*****If yes to this section, patient qualifies for regular dose of Moderna 0.5 milliliters – REGULAR DOSE*****		

Do you have any of or are any of the following?	**Yes**	**No**
COPD or other lung/pulmonary disease/current smoker/former smoker		
Kidney, liver, neurologic, or heart disease (any of these)		
Obesity/Overweight		
Diabetes		
Immunocompromised system from other disease or ailment		
Substance use disorder		
Depression or other mental health concerns		
Previous stroke or neurologic disease (Dementia, Alzheimer's)		
****If yes to any in this section, patient qualifies for a ONE-HALF dose (0.25 mL) Moderna OR regular dose Janssen****		

I have been given a copy and have read the Emergency Use Authorization (EUA) and reviewed the FDA Fact Sheet for Recipients and Caregivers for the COVID-19 vaccine product I will be administered one of the following:
Moderna (age 18 and over) or Janssen (age 18 and over)

I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine indicated and ask that it be given to me, or the person named for whom I am authorized to make this request.

My signature acknowledges that it is recommended to remain on site for 15 minutes after receiving the vaccine. Those with previous severe or anaphylactic reactions should stay for 30 minutes

_____ _____ **X** _____

Date **Print Name** **Patient or Parent/Guardian Signature**

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• Have you received a complete COVID-19 vaccine series *(i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna])*?	☐	☐	
• Did you bring your vaccination record card or other documentation?	☐	☐	
3. Have you ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following: ○ 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	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
4. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré Syndrome (GBS)

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists