# Colorado COVID-19
# Vaccine Screening and Administration Form

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

EXAMPLE 123

*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 ☐ Asian ☐ Black, African American ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ White ☐ Decline to Provide

**Health Insurance** **(OPTIONAL-INSURANCE NOT REQUIRED FOR VACCINATION)** ☐ Medicaid ☐ Medicare ☐ Kaiser Permanente ☐ United Healthcare ☐ Other Private ☐ No Insurance **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** _____/_____/_____ ***OTHER 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 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** | **M.I.**

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

**Age (years)**

**Dose Number:** 1 ☐ 2 ☐ 3 ☐

**Booster Dose:** 1 ☐

## 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 ☐ Public ☐ Private

Clinic Name

Provider Name

**Manufacturer**
- ☐ PFR (Pfizer)
- ☐ Moderna
- ☐ Janssen
- ☐ AstraZeneca
- ☐ Novavax

Brand Name

Lot Number

**Primary Dose**
- ☐ 0.3 ml
- ☐ 0.5 ml

**Pediatric Dose** (age 5-11 y.o.)
- ☐ 0.2 ml
- ☐

**Booster Dose**
- ☐ 0.25 ml Moderna
- ☐ 0.3 ml Pfizer
- ☐ 0.5 ml J&J

**Site**
- ☐ LD ☐ LT
- ☐ RD ☐ RT

**Date Administered** 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: The same product used for the primary doses should be used for the booster, if not available or another product preferred, heterologous boosting (see below) with a single dose of another authorized COVID-19 vaccine booster is acceptable.

- **Pfizer booster dose information:**
  - A single booster dose of the Pfizer-BioNTech COVID-19 Vaccine *should* be administered at least 6 months after completion of the primary series to:
    - People aged 65 years and older
    - Residents aged 18 years and older in long-term care settings
    - Individuals age 50-64 years of age with underlying medical conditions
  - A single booster dose *may* be administered at least 6 months after completion of the primary series, based on individual benefits and risks to:
    - People age 18-49 years with underlying medical conditions
    - Individuals 18 through 64 years of age with frequent institutional or occupational exposure to SARS-CoV-2
- **Moderna booster dose information:**
  - A single booster dose of the Moderna COVID-19 Vaccine that may be administered at least 6 months after completion of the primary series to individuals:
    - People aged 65 years and older
    - 18 through 64 years of age at high risk of severe COVID-19
    - Individuals 18 through 64 years of age with frequent institutional or occupational exposure to SARS-CoV-2
- **Janssen (J & J) booster dose information:**
  - A single booster dose of the Janssen (Johnson and Johnson) COVID-19 Vaccine may be administered at least 2 months after completion of the single-dose primary regimen to individuals 18 years of age and older.
- *The eligible population(s) and dosing interval for a heterologous booster dose are the same as those authorized for a booster dose of the vaccine used for primary vaccination.*
  - *Heterologous dosing may be considered for the booster dose, only.*
  - *Individual benefit-risk assessment may inform which booster product to use*