COVID-19 VACCINATION SCREENING & ENCOUNTER FORM

DATE: VDH Client ID#

Last Name	First Name	Middle Name	Birth Date
			____/____/____

Address (Not a PO Box)	**Street**_____ **City**_____ **State**_____ **Zip** _____

Gender ☐M ☐F	**Race**	☐American Indian/Alaskan Native ☐Asian ☐Black or African American ☐Hawaiian Native or Other Pacific Islander ☐White ☐Not Stated	**Hispanic/Latino** ☐Yes ☐No

Home Phone **Cell Phone** **Email**

I consent to receive vaccination information or reminders by ☐ Text message ☐ Email

Insurance Type: ☐ Private Ins ☐ Medicaid/medical assistance ☐ Medicare ☐ No Insurance

I hereby authorize the administration of the COVID-19 vaccination to myself or to the person named below for whom I am the legal representative. I have read or have had explained to me the 2020-21 Vaccine Information Statement or the Emergency Use Authorization Fact Sheet for the COVID-19 vaccine and understand the risks and benefits. I have had the opportunity to ask questions about this immunization. I believe the benefits outweigh the risks, and I accept full responsibility for any reactions that may result from my receipt of the immunization or the receipt of the immunization by the person named below for whom I am the legal representative. I agree that the immunization record may be shared as stated in the Notice of Privacy Practices, which includes sharing with health care providers and to support the application for payment by Medicare, Medicaid, and other third party payor. I request the third party payer to pay any authorized benefits to VDH on my behalf. The Notice of Deemed Consent for blood borne diseases has been explained to me and I understand it.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any VDH health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.
2. If you should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the tests.

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read the Notice of Privacy Practices from the Virginia Department of Health.

OFFICE USE ONLY

Vaccine	Lot Number	Route	Administration Site	Provider/#
COVID-19 Vaccine **Moderna** (0.5 mL)		IM	☐ RA ☐ LA	
Admin (circle one) **Moderna** 1st dose 2nd dose				
COVID-19 Vaccine **Pfizer** (0.3 mL)		IM	☐ RA ☐ LA	
Admin (circle one) **Pfizer** 1st dose 2nd dose				
COVID-19 Vaccine **Janssen** (0.5 mL) single dose		IM	☐ RA ☐ LA	

Patient, Parent/Legal Guardian, Person Acting in Loco Parentis-Printed Name Signature Date

Provider Printed Name Signature Date

SCREENING QUESTIONNAIRE ON BACK

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name _____

Age _____

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.

	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 ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product _____			
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 occurred within 4 hours 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.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Form reviewed by _____ **Date** _____