



Colorado COVID-19 Vaccine Screening and Administration Form



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

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.

E X A M P L E **1 2 3**

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	Age (years)	Patient/Representative Daytime Phone Number
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>M M D D Y Y Y Y</small>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Parent First Name	Parent Last Name
If under 18 years of age please complete	

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?	Race(s) check all that apply
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Provide	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black, African American <input type="checkbox"/> Other <input type="checkbox"/> Decline to Provide <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White

Health Insurance (OPTIONAL-INSURANCE NOT REQUIRED FOR VACCINATION)	Insurance Policy Number
Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Kaiser Permanente <input type="checkbox"/> United Healthcare <input type="checkbox"/> Other Private <input type="checkbox"/> No Insurance <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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)			

Last Name	First Name	M.I.
<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of Birth	Age (years)	Dose Number: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	Booster Dose: 1 <input type="checkbox"/>
M M / D D / Y Y Y Y		

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
<input type="text"/>	<input type="checkbox"/> Public <input checked="" type="checkbox"/> Private	PARTNERS IN PEDIATRICS	RUBIN, JERRY
Manufacturer	Brand Name	Primary Dose	Booster Dose
<input checked="" type="checkbox"/> PFR (Pfizer) <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen <input type="checkbox"/> AstraZeneca <input type="checkbox"/> Novavax	P F I Z E R	<input type="checkbox"/> 0.3 ml <input type="checkbox"/> 0.5 ml Pediatric Dose (age 5-11 y.o.) <input checked="" type="checkbox"/> 0.2 ml <input type="checkbox"/>	<input type="checkbox"/> 0.25 ml Moderna <input type="checkbox"/> 0.3 ml Pfizer <input type="checkbox"/> 0.5 ml J&J
Lot Number	Date Administered	Site	
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> LD <input type="checkbox"/> LT <input type="checkbox"/> RD <input type="checkbox"/> RT	
		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*