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.

Patient/Child Last Name | **Patient/Child First Name** | **M.I.**

Date of Birth (M M / D D / Y Y Y Y) | **Age (years)** | **Age (months)** | **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 ☐ Black, African American ☐ Other ☐ Decline to Provide
☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White

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** _____/_____/_____ ***Additional Booster 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 received any dermal fillers (Juvaderm®, Restylane®, etc.)? (only applies to mRNA vaccines)			
8.	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)			
9.	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)			
10.	Do you or your child have a history of heparin-induced thrombocytopenia (HIT)?			
11.	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?			
12.	Are you or your child immunocompromised? (See additional dose section on next page)			

Continued on Next Page

Patient/Child Last Name | **Patient/Child First Name** | **M.I.**

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

Age (years) **Age (months)**

Primary Dose : 1 ☐ 2 ☐ 3 ☐

Booster Dose: 1 ☐ 2* ☐

Authorization to Administer COVID-19 Vaccine

I have read or had explained to me the Fact Sheet for Recipients and Caregivers 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

Brand Name

Lot Number

Primary Dose

Pfizer (age 12 years +) ☐ 0.3 ml
Moderna (age 18 years +) ☐ 0.5 ml
J&J (age 18 years +) ☐ 0.5 ml

Booster Dose

Pfizer ☐ 0.3 ml
Moderna ☐ 0.25 ml
J&J ☐ 0.5 ml

Pfizer (*Orange Cap*) (ages 5 - 11 years) **Pediatric Primary and Booster Dose** ☐ 0.2 ml

Pfizer (*Maroon Cap*) (ages 6 mo. - 4 years) **Pediatric Primary Dose** ☐ 0.2 ml

Moderna (ages 6 mo. - 5 years) **Pediatric** Primary Dose ☐ 0.25 ml

Site ☐ LD ☐ LT ☐ RD ☐ RT

Date Administered M M / D D / Y Y Y Y

Administered by:

Name _____ Title _____

For vaccine administration guidance, including: timing, dosing, site selection, needle length and gauge, and administration procedures, please reference your standing orders or the CDC's Interim Clinical Considerations".

https://covid19.colorado.gov/vaccine-providers

https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

https://www.immunize.org/covid-19/

*Additional guidance from the FDA for 2nd booster dose is as follows:

- A second booster dose of either the Pfizer-BioNTech COVID-19 Vaccine or Moderna COVID-19 Vaccine may be administered to individuals 50 years of age and older at least 4 months after receipt of a first booster dose of any authorized or approved COVID-19 vaccine.
- A second booster dose of the Pfizer-BioNTech COVID-19 Vaccine may be administered to individuals 12 years of age and older with certain kinds of immunocompromising conditions at least 4 months after receipt of a first booster dose of any authorized or approved COVID-19 vaccine. These are people who have undergone solid organ transplantation, or who are living with conditions that are considered to have an equivalent level of immunocompromise.
- A second booster dose of the Moderna COVID-19 Vaccine may be administered at least 4 months after the first booster dose of any authorized or approved COVID-19 vaccine to individuals 18 years of age and older with the same certain kinds of immunocompromise.

***Additional Guidance for J &J Vaccine use:**

- Assess persons 18 years of age and older for vaccination with Janssen COVID_19 Vaccine based on the following criteria:
    - mRNA COVID-19 Vaccines are *preferred* over Janssen COVID-19 Vaccine for primary series and booster vaccination
    - Inform all persons receiving a Janssen vaccine of the risks and symptoms of thrombosis with thrombocytopenia syndrome (TTS) in the 3 weeks after vaccination as was as the need to seek immediate care should symptoms develop.
- Janssen COVID-19 Vaccine may be offered in some situations:
    - A true contraindication to mRNA vaccines (severe allergic reaction to a previous dose or a component of the vaccine
    - The person would otherwise remain unvaccinated for COVID-19 due to limited access to mRNA vaccine
    - The person wants to receive the Janssen COVID-19 vaccine despite the safety concerns identified