## **COVID-19 Vaccine Documentation/Consent Form**

Patient Information (Please print legibly)					
Las	ast Name: Middle na	ame:			
Da	ate of Birth: Biological Sex: □ Female □ Male □ Ur	ıknown or Not Reported			
<b>Ethnicity:</b> □ Non-Hispanic/Latino □ Hispanic/Latino (Central/South America, Mexico, Cuba, Puerto Rico, Other) □ Unknown/Not Reported					
Race 1: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native					
☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown or Not Reported					
Race 2: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown or Not Reported					
	Race 3: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown or Not Reported				
Re	esidential Address: City:				
	ate: Zip: County:				
Ph	none: Email:				
Screening Questionnaire COVID-19 Screening Questions					
2. 3.	In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?  In the past two weeks, have you had contact with anyone who tested positive for CO'Do you currently or have you in the past two weeks had a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?  Patient temperature: Date:	□ Yes □ No VID-19? □ Yes □ No □ Yes □ No			
Immunization Screening Questions					
<ol> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> <li>7.</li> </ol>	Have you ever had Guillain-Barre syndrome?  Are you pregnant or is there a chance you could become pregnant in the next month?  Are you currently breastfeeding?  Do you have a blood-clotting disorder or are currently taking blood thinners?  Do you have a long-term health problem such as heart disease, lung disease, liver disease.	□ Yes □ No □ Yes □ No isease, □ Yes □ No			
	asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disease pour have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitists. Crohn's disease or other condition that makes it hard for you to fight infections?  Do you have a weakened immune system or in the past 3 months, taken medications it such as cortisone, prednisone, other steroids, anti- cancer drugs or radiation treatments.	s, □ <i>Yes</i> □ <i>No</i> s that weaken			

11. During the past year, have you received a transfusion of	•		
or been given immune (gamma) globulin or an antiviral o	□ Yes □ No		
12. In the past 4 weeks, have you received any vaccinations	□ Yes □ No		
13. Do you have a disability?		□ Yes □ No	
I have been offered a copy of the COVID-19 Emergency U to me, and understand the information in the EUA. I ask the inclusion of this immunization data in the Kansas Immunization	nat the vaccine be administered	d to me. I consent to	
Signature of Patient	Date		
Printed Name of Patient	Date of Birth		
If patient is a minor:			
Signature of Parent/Guardian	Date		
Printed Name of Parent/Guardian			
For Office Us	e Only		
Vaccine: COVID-19	Route: Intramu	scular <b>Dose:</b> mL	
Manufacturer: ☐ Moderna ☐ Pfizer ☐ J&J ☐ Other _			
Lot Number:	Site: Deltoid □	Site: Deltoid □ Left □ Right	
Expiration Date:	□ Other		
Administered Rv	Date Given:		

Signature and Title of Vaccine Administrator