Coffey Health System

COVID-19 VACCINATION SCREENING AND CONSENT FORM

Patient Label

First and Last Name *(please print)*			MI	Date of Birth	
Address		City		State	Zip
Phone Number	Email	Name of Primary Care Provider			

SCREENING FOR VACCINATION ELIGIBILITY

Question		
1. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause?	Yes	No
2. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of a COVID-19 vaccine, including lipid nano particles or polyethylene glycol (PEG)?	Yes	No
3. Have you received convalescent plasma or monoclonal/polyclonal antibody infusion for COVID-19 with the past 90 days?	Yes	No
4. Are you under the age of 18?	Yes	No
5. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?	Yes	No
6. Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No
7. Have you tested positive for COVID-19 in the last 10 days?	Yes	No
8. Are you currently in quarantine for COVID-19 exposure?	Yes	No
9. Have you been diagnosed with Multisystem Inflammatory Syndrome in the last 90 days? (if you answer yes to this question, it is recommended you consult with you physician prior to receiving the COVID-19 vaccine)	Yes	No
10. Have you ever been diagnosed with myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the outer lining of the heart)?	Yes	No
11. If this is your second dose, when was the date of your first dose?	/ /	
12. If this is your second dose, which vaccine did you receive? (Pfizer or Moderna)		
13. Do you meet any of the following criteria: Age 65 or older; age 18 or older with an underlying medical condition; severely or moderately immunocompromised; age 18 or older and work or living in a high-risk or long-term care setting?	Yes	No
14. If this is a booster dose, which vaccine did you receive as your primary vaccine? (Moderna, Pfizer, or Johnson & Johnson)		
15. If this is a booster dose, when was the date of you second dose of the Moderna or Pfizer vaccines, or the date of your first dose of Johnson & Johnson (Janssen) vaccine?	/ /	

CONSENT FOR VACCINATION

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have been provided with a copy of the Emergency Use Authorization (EUA) Fact Sheet or Vaccination Statement (VIS) today. I believe I understand the benefits and risks of the COVID-19 vaccine. I have had the opportunity to ask questions that were answered to my satisfaction.

By signing this form, I give permission for a vaccine to be administered to the person above whom I am authorized to make this request for, and I consent to inclusion of this immunization data to in the Kansas Immunization Registry.

Patient or Authorized Representative Signature **Date**

Relationship to Patient *(If applicable)*