COVID-19 VACCINE SCREENING FORM

County of San Luis Obispo Public Health Department
2191 Johnson Ave, San Luis Obispo, CA 93401
Phone: 805-781-5500 | Fax: 805-781-5543 | www.slopublichealth.org

Haga clic aquí para el formulario Español

2020-2021

DEMOGRAPHIC INFORMATION

Last Name: _____ **First Name:** _____ **Middle Initial:** ____

Street Address: _____ **Mother's First Name:** _____

City: _____ **ZIP:**_____ **Gender:** ☐ Male ☐ Female ☐ Decline to state

Phone (xxx-xxx-xxxx): _____

Birthdate (mm/dd/yyyy): _____

Email: _____

RACE (select 1): ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black or African-American ☐ White Other *(fill in below):* _____

Ethnicity (select 1): ☐ ***HISPANIC OR LATINO*** ☐ ***NOT HISPANIC OR LATINO***

HEALTH HISTORY INFORMAITON

	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 and on what date(s):			
☐ Pfizer Date(s): _____ ☐ Moderna Date(s): _____ ☐ Janssen (Johnson & Johnson) Date: _____ ☐ Another Product: _____ Date: _____			
• Did you bring your vaccination record card or other documentation? *(yes/no)*	☐	☐	
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 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	☐	☐	☐
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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer)
- ☐ Take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of herparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ Had a positive test for COVID-19 or been told by a doctor that you had Covid-19

I, the undersigned, certify that all of the above information is correct to the best of my knowledge.

_____ _____

Signature Date Relationship to person named on this form:

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Acknowledgment of Vaccine Information, Privacy Practices, and Self-Attestation

☐ I have read or had explained to me the ***COVID-19 Vaccine Information Statement***. I have had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and request that it to be given to me or to the person for whom I am authorized to make this request.

Link for Pfizer BioNTech ***COVID-19 Vaccine Information Statement***: *https://www.fda.gov/media/144414/download*

Link for Moderna ***COVID-19 Vaccine Information Statement:*** *https://www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-recipients.pdf*

Link for Janssen (J&J) ***COVID-19 Vaccine Information Statement:*** *https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/COVID-19/JnJ_factsheet.pdf*

☐ I hereby acknowledge that I have been offered or have received a copy of San Luis Obispo County Health Agency's Notice of Private Practices. I further acknowledge that a copy of the current notice is posted in the reception area of each clinic and I will be offered a copy.

Signature (Patient) Date

Signature (Parent or Guardian) Date

Name - PLEASE PRINT

Name - PLEASE PRINT

Phone Consent / Video Call Consent for 12-17 y/o

Witness Name / Signature Date

Parent / Guardian Name

~Do Not Write Below This Line~

Medical Evaluation By:	Administered By:	Injection Site:
Print Name	Print Name	
Full Signature & suffix	Full Signature & suffix	

Vaccinate? Yes ☐ No ☐

Vaccine Lot

[Affix Label Here]