Haga clic aquí para el formulario Español

COVID-19 VACCINE SCREENING FORM 2020-2021

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

DEMOGRAPHIC INFORMATION

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

Street Address: _____

City: _____ **ZIP:**_____

Phone (xxx-xxx-xxxx): _____

Birthdate (mm/dd/yyyy): _____

Weight (lbs): _____ **Mother's First Name:** _____

Gender: ☐ Male ☐ Female ☐ Decline to state

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

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

HEALTH HISTORY INFORMAITON

1.	Have you ever received a dose of COVID-19 vaccine? (If Yes, which product?) ◯ Pfizer ◯ Moderna Date of Dose:	Yes ◯	No ◯	Not Sure ◯
2.	Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	Yes ◯	No ◯	Not Sure ◯
3.	Are you feeling sick today?	Yes ◯	No ◯	Not Sure ◯
4.	Are you or could you be pregnant or are you breastfeeding at this time?	Yes ◯	No ◯	Not Sure ◯
5.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?	Yes ◯	No ◯	Not Sure ◯
	a. Was the severe allergic reaction after receiving a COVID-19 vaccine?	Yes ◯	No ◯	Not Sure ◯
	b. Was the severe allergic reaction after receiving another vaccine or another injectable medication?	Yes ◯	No ◯	Not Sure ◯
6.	Do you have a bleeding disorder or are you taking a blood thinner?	Yes ◯	No ◯	Not Sure ◯
7.	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	Yes ◯	No ◯	Not Sure ◯
8.	Have you received passive antibody therapy as treatment for COVID-19?	Yes ◯	No ◯	Not Sure ◯

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

_____ Relationship to person named on this form:

Signature Date

****PLEASE TURN THIS FORM OVER FOR HIPAA ACKNOWLEDGMENT****

~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]

COUNTY OF SAN LUIS OBISPO

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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 Date Relationship to person named on this form:

Name - PLEASE PRINT

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

Witness Name / Signature Date

Parent / Guardian Name

DIRECTIONS FOR VACCINE EVENT

ARROYO GRANDE - South County Regional Center
800 W Branch St, Arroyo Grande, CA 93420