



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 Other (fill in below): Black or African-American White

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

HEALTH HISTORY INFORMATION

- 1. Have you ever received a dose of COVID-19 vaccine? (If Yes, which product?) Yes No Not Sure
Pfizer Moderna Date of Dose:
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? Yes No Not Sure
For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?
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.

Signature _____ Date _____ Relationship to person named on this form: _____

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

~Do Not Write Below This Line~

Medical Evaluation By:
Print Name
Full Signature & suffix

Administered By:
Print Name
Full Signature & suffix

Injection Site:

Vaccinate?
Yes No
[] []

Vaccine Lot

[Affix Label Here]



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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-recipient.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

CUESTA COLLEGE
CULTURAL AND PERFORMING ARTS CENTER
<https://g.page/CuestaCPAC>

