SACRAMENTO COUNTY PUBLIC HEALTH
Promote • Prevent • Protect

Immunization Assistance Program
COVID-19 Vaccine Screening & Consent Form

NAME: _____ **DOB:** _____ **AGE:** _____ **GENDER:** _____
(First) (Last) MM/DD/YYYY

RACE: _____ **ETHNICITY:** _____ **MOTHER'S FIRST NAME:** _____ **EMAIL:** _____

PHONE: ( ) _____ **ADDRESS:** _____ **CITY:** _____ **ZIP:** _____

Please check **YES** or **NO** box for the following questions **and** answer **ALL** questions.

Yes	No	
☐	☐	Are you feeling sick today?
☐	☐	Have you received a dose of COVID-19 vaccine?

If yes, which vaccine product(s) did you receive? Reaction to dose received? _____

Dose 1 ☐ Pfizer: _____ (Date) ☐ Moderna: _____ (Date) ☐ Janssen: _____ (Date) ☐ Other: _____ (Date)

Reaction to dose received? _____

Dose 2 ☐ Pfizer: _____ (Date) ☐ Moderna: _____ (Date) ☐ Janssen: _____ (Date) ☐ Other: _____ (Date)

Reaction to dose received? _____

Booster1 ☐ Pfizer: _____ (Date) ☐ Moderna: _____ (Date) ☐ Janssen: _____ (Date) ☐ Other: _____ (Date)

Reaction to dose received? _____

Booster2 ☐ Pfizer: _____ (Date) ☐ Moderna: _____ (Date) ☐ Janssen: _____ (Date) ☐ Other: _____ (Date)

Have you ever had an allergic reaction to:

☐	☐	Polyethylene glycol (PEG) found in medications such as laxative and bowel preps for colonoscopy.
☐	☐	Polysorbate found in some vaccines, film coated tablet, and intravenous steroids.
☐	☐	Have you ever had a severe allergic reaction (e.g. anaphylaxis) to medication (includes other vaccines and injectable medication), food, pet venom, or environment for which you were treated with epinephrine or EpiPen, or had to go to the hospital? If yes, explain: _____

Check all that apply to you:

- ☒ Have a history of myocarditis or pericarditis
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum. When_____
- ☐ Diagnosed with Multisystem inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (for example, cancer or HIV infection)
- ☐ Take immunosuppressive drugs or therapies
- ☐ Bleeding disorder
- ☐ Take a blood thinner medication
- ☐ History of heparin-induced thrombocytopenia (HIT)
- ☐ Currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré syndrome

I have received, read, and understand the "Fact Sheet for Recipients and Caregivers" about the "Emergency Use Authorization (EUA) for the COVID-19 vaccine. I understand the benefits and risks of receiving this Covid-19 vaccine. I have had an opportunity to ask questions which were answered to my satisfaction. I hereby provide informed consent that the vaccine indicated below be given to me or to the person named above for whom I am authorize to make this request. Immunization given today will be enter into CAIR and share unless I object.

Recipient/Parent/Guardian's Signature: _____ _____ Date: _____
Relationship's to person above

For Official Use	Date	Vaccine & Mfg	Lot #	BUD/ Expiry	Dosage	Dose number	Administered By	Title	IM Site	
									LT	RT
									LD	RD

Updated 12-5-22