

Colorado COVID-19

Vaccine Administration and Screening Form



Please print neatly in capital letters as shown in the example below

E X A M P L E 1 2 3

Please answer all questions as completely as possible

Footnotes for precautions/contraindications are on back of this document

Personal Information. Provide information as completely as you can. All information will be kept confidential.

Last Name				First Name				MI	Gender
<input type="text"/>				<input type="text"/>				<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F
Street No. or PO Box		Street Name				Apt. Number			
<input type="text"/>		<input type="text"/>				<input type="text"/>			
City				County		State	Zip Code		
<input type="text"/>				<input type="text"/>		<input type="text"/>	<input type="text"/>		
Phone		E-mail							
<input type="text"/>		<input type="text"/>							
Date of Birth		Race/Ethnicity (Check all that apply)							
<input type="text"/>		<input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black, African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Other							
Health Insurance Information							Insurance Policy Number		
<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Kaiser Permanente <input type="checkbox"/> Other Private <input type="checkbox"/> No Insurance							<input type="text"/>		

Health Screening Questions	Yes*	No
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a serious allergy to food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction to a previous dose of vaccine or any medication?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had severe allergic reaction to any component of either of the mRNA COVID-19 vaccines licensed in the US?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you pregnant, or is there a chance you may become pregnant in the next 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you received any vaccinations in the last 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you been ill with or recovered from a <i>confirmed</i> COVID infection within the past 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you had convalescent plasma or monoclonal antibodies as part of COVID-19 treatment in the past 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have any of the following illnesses or conditions? Chronic lung disease (including asthma), heart disease, diabetes, brain, spinal cord or muscle illness that causes swallowing or lung problems, problems with the immune system caused by medications and/or HIV, kidney disease, liver disease, blood disorders	<input type="checkbox"/>	<input type="checkbox"/>

Please identify Phase Category you are in (please choose only one)

<input type="checkbox"/> 1A-Highest risk: Direct contact w COVID patients, LTC staff/residents <input type="checkbox"/> 2-Higher risk and other essential workers: Age 60-69; Individuals age 16-59 with obesity, diabetes, chronic lung disease, significant heart disease, chronic kidney disease, cancer, or are immune compromised; 2) Other essential workers and continuity of local government; 3) Adults who received the placebo in Clinical Trials.	<input type="checkbox"/> 1B-Moderate Risk: Moderate risk HCW's; first responders, age 70 +; Frontline essential workers and continuity of state government: 1) Health care workers with less direct contact (home health, hospice, pharmacy, dental, etc.), EMS; 2) Firefighters, police, COVID-19 response personnel, corrections, funeral services; 3) Frontline essential workers- Education (teachers, daycare); Food & Agriculture, Manufacturing; USPS: Public transit and specialized transportation services; Grocery; Public Health: frontline essential human services workers and direct care providers for Coloradans experiencing Homeless; 4) Essential officials from Executive, Legislative and Judiciary Branches of state gov.; 5) Essential frontline journalists <input type="checkbox"/> 3-General Public: Anyone ages 16-59
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Authorization to Administer COVID-19 Vaccine
 I have read or had explained to me, and I understand the risks and benefits of receiving the COVID-19 vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I hereby release this provider, its employees and its volunteers from any liability for any results which may occur from the administration of this vaccine.

Patient, Parent/Guardian Signature: _____ Date: _____

STOP - DO NOT WRITE BELOW THIS LINE

COVID/VFC PIN		Clinic Name		Provider Type: <input type="checkbox"/> Public <input type="checkbox"/> Private		Prescribing Provider Name				
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>				
Manufacturer		Dosage	Lot No.			Site:		Date Administered		
<input type="checkbox"/> PFR (Pfizer) <input type="checkbox"/> AstraZeneca/Oxford Biomedica <input type="checkbox"/> Moderna <input type="checkbox"/> J&J <input type="checkbox"/> SP/GSK		<input type="checkbox"/> 0.3 ml <input type="checkbox"/> 0.5 ml	<input type="text"/>			<input type="checkbox"/> LD <input type="checkbox"/> LT <input type="checkbox"/> RD <input type="checkbox"/> RT		<input type="text"/>		
						Administered by:				
						Name _____ Title _____				

Precautions/Contraindications for vaccination

Triage of persons presenting for mRNA COVID-19 vaccination

	MAY PROCEED WITH VACCINATION	PRECAUTION TO VACCINATION	CONTRAINDICATION TO VACCINATION
CONDITIONS	CONDITIONS <ul style="list-style-type: none"> Immunocompromising conditions Pregnancy Lactation 	CONDITIONS <ul style="list-style-type: none"> Moderate/severe acute illness 	CONDITIONS <ul style="list-style-type: none"> None
	ACTIONS <ul style="list-style-type: none"> Additional information provided 15 minute observation period 	ACTIONS <ul style="list-style-type: none"> Risk assessment Potential deferral of vaccination 15 minute observations period if vaccinated 	ACTIONS <ul style="list-style-type: none"> N/A
ALLERGIES	ALLERGIES <ul style="list-style-type: none"> History of allergies that are unrelated to the components of an mRNA COVID-19 vaccine licensed in the US, other vaccines, injectable therapies, or polysorbate, such as: <ul style="list-style-type: none"> Allergy to oral medications (including the oral equivalent of an injectable medication) History of food, pet, insect, venom, environmental, latex, etc., allergies Family history of allergies 	ALLERGIES <ul style="list-style-type: none"> History of any immediate allergic reaction[#] to vaccines or injectable therapies (except those related to component of the mRNA COVID-19 vaccines licensed in the US or polysorbate, as these are contraindicated) 	ALLERGIES <p>History of the following are contraindications to receiving either of the mRNA COVID-19 vaccines licensed in the US:</p> <ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose of an mRNA COVID-19 vaccine or any of it's components Immediate allergic reaction[#] of any severity to a previous dose of an mRNA COVID-19 vaccine or any of it's components (including polyethylene glycol)[^] Immediate allergic reaction of any severity to polysorbate^{*^}
	ACTIONS <ul style="list-style-type: none"> 30 minute observation period: Persons with a history anaphylaxis due to any cause 15 minute observation period: Persons with allergic reaction, but not anaphylaxis 	ACTIONS <ul style="list-style-type: none"> Risk assessment Potential deferral of vaccination and/or referral to allergist-immunologist 30 minute observation period if vaccinated 	ACTIONS <ul style="list-style-type: none"> Do not vaccinate[^] Consider referral to allergist-immunologist

[#] Any hypersensitivity-related signs or symptoms consistent with urticaria, angioedema, respiratory distress (e.g., wheezing, stridor), or anaphylaxis that occur within four hours following administration.

[^]These persons should not receive mRNA COVID-19 vaccination at this time unless they have been evaluated by an allergist-immunologist and it is determined that the person can safely receive the vaccine (e.g., under observation, in a setting with advanced medical care available)

^{*}Polyethylene glycol (PEG), an ingredient in both mRNA COVID-19 vaccines, is structurally related to polysorbate and cross-reactive hypersensitivity between these compounds may occur. Information on ingredients of a vaccine or medication (including PEG, a PEG derivative, or polysorbates) can be found in the package insert.

Regarding "Yes" answer to:

Question 7: Recent illness-defer until recovery from acute illness and criteria have been met to discontinue isolation. This recommendation applies to persons who develop SARS-CoV-2 infection before receiving any vaccine doses as well as those who develop SARS-CoV-2 infection *after the first dose but before receipt of the second dose*. While there is otherwise no recommended minimum interval between infection and vaccination, [current evidence](#) suggests that reinfection is uncommon in the 90 days after initial infection. Thus, persons with documented acute SARS-CoV-2 infection in the preceding 90 days may delay vaccination until near the end of this period, if desired.

Question 8: Currently, there are no data on the safety and efficacy of mRNA COVID-19 vaccines in persons who received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment. Based on the estimated half-life of such therapies as well as [evidence](#) suggesting that reinfection is uncommon in the 90 days after initial infection, vaccination should be deferred for at least 90 days, as a precautionary measure until additional information becomes available, to avoid interference of the antibody treatment with vaccine-induced immune responses.