UHS

1st / 2nd / 3rd Dose COVID-19 Immunization Screening and Consent Form*

Recipient Name (please print)	**Preferred Name**	□ **Employee** **Employee #**_____

DOB	**Current Gender ID** Indicate ID Below:	**Key:** W- Woman/Girl TM- Transgender Man/Boy Q- Not sure/Questioning	GNL- Gender not Listed (write-in) TW- Transgender Woman/Girl NB- Non-Binary Person *Gender Pronouns: write-in by client's name	NR- Chose not to Respond M- Man/Boy GNC- Gender Non-Conforming

Sex Assigned at Birth Indicate Sex Below:	**Key:** M- Male F- Female I- Intersex NR- Chose not to respond	**Marital Status** Indicate Status Below:	**Key:** S- Single W- Widowed SEPARATED- Legally Separated	D- Divorced V- Civil Union PARTNER- Life Partner	M- Married U-Unknown

Address	**City**	**State**	**Zip**	**Email Address**

Parent/Guardian/Surrogate (if applicable, please print)	**Phone**	**Preferred Language**

Ethnicity Indicate Ethnicity Below:	**Ethnicity Key:** DECL- Declined HIS- Hispanic Origin NHL- Non-Hispanic Origin UNK- Unknown	**Race** Indicate Race Below:	**Key:** AIA- Native American or Alaskan BAA- African American or Black NHP- Native Hawaiian or Pacific	WHT- White ASN- Asian DECL- Decline OTH- Other or Multiracial

Clinic/Office Site Where Vaccine is Administered	**Primary Care Physician Address/Phone Number**

	Screening Questionnaire			
1.	Are you feeling sick today?	□ Yes	□ No	
2.	In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a health care provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	□ Yes	□ No	□ Unknown
3.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?* _____	□ Yes	□ No	□ Unknown
4.	Have you ever had an immediate allergic reaction (e.g. hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything?	□ Yes	□ No	□ Unknown
5.	Are you pregnant or considering becoming pregnant?	□ Yes	□ No	□ Unknown
6.	Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?	□ Yes	□ No	□ Unknown
7.	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	□ Yes	□ No	□ Unknown
8.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?	□ Yes	□ No	□ Unknown
9.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	□ Yes	□ No	□ Unknown
10.	Are you 65 years old or older?	□ Yes	□ No	□ Unknown
11.	Are you 18 years old or older AND a resident of a long-term care facility?	□ Yes	□ No	□ Unknown
12.	Are you 50 through 64 years old AND have one or more of the following conditions (due to increased risk of moderate or severe illness or death from the virus that causes COVID-19): 1) Cancer (current or in remission, including 9/11-related cancers); 2) Chronic kidney disease; 3) Pulmonary Disease, including but not limited to, COPD (chronic obstructive pulmonary disease), asthma (moderate to severe), pulmonary fibrosis, cystic fibrosis, and 9/11 related pulmonary diseases; 4) Intellectual and Developmental Disabilities including Down Syndrome; 5) Heart conditions, including but not limited to heart failure, coronary artery disease, cardiomyopathies, or hypertension (high blood pressure); 6) Immunocompromised state (weakened immune system) including but not limited to solid organ transplant or from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, use of other immune weakening medicines, or other causes; 7) Severe Obesity (BMI 40 kg/m2), Obesity (body mass index (BMI) of 30 kg/m2 or higher but < 40 kg/m2); 8) Pregnant; 9) Sickle cell disease or Thalassemia; 10) Type 1 or 2 diabetes mellitus; 11) Cerebrovascular disease (affects blood vessels and blood supply to the brain); 12) Neurologic conditions including but not limited to Alzheimer's Disease or dementia; 13) Liver disease limited to cirrhosis, non-alcoholic fatty liver disease, alcoholic liver disease, or autoimmune hepatitis; 14) Current or former smoker; 15) Substance use disorder; 16) Mental health disorders limited to mood disorders including depression, schizophrenia spectrum disorders.	□ Yes	□ No	□ Unknown
13.	Are you 18 through 49 years old AND have one or more underlying medical conditions listed above, and are seeking a booster because the benefits outweigh the risks?	□ Yes	□ No	□ Unknown
14.	Are you 18 through 64 years old AND are at increased risk for COVID-19 exposure and transmission because of occupational or institutional setting?	□ Yes	□ No	□ Unknown
15.	Have you received 2 doses of the Pfizer vaccine, the second dose being at least 6 months ago?	□ Yes	□ No	Date:_____ (if applicable)
16.	Have you received 2 doses of the Moderna vaccine, the second dose being at least 6 months ago?	□ Yes	□ No	Date:_____ (if applicable)
17.	Have you received a previous dose of the Janssen vaccine, at least 2 months ago?	□ Yes	□ No	Date:_____ (if applicable)
18.	Have you received a dose of the Janssen (Johnson & Johnson), did you develop thrombosis with thrombocytopenia syndrome (TTS)?	□ Yes	□ No	□ Unknown
19.	Have you received a previous dose of a COVID-19 vaccine authorized by the WHO but not by the FDA (AstraZeneca – VAXZEVRIA, Sinovac – CORONAVAC, Serum Institute of India – COVISHIELD, Sinopharm)?	□ Yes	□ No	□ Unknown

*Questions #10-17 pertain to booster dose eligibility.