Colorado COVID-19
Vaccine Administration and Screening Form

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

EXAMPLE 1 2 3

Please answer all questions as completely as possible

Use reverse side for notes

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

Last Name
First Name
MI
Gender
M F

Street No. or PO Box
Street Name
Apt. Number

City
County
State

Zip Code
Phone
E-mail

Date of Birth
Race/Ethnicity (Check all that apply)

Asian
Black, African American
Native Hawaiian/Pacific Islander
American Indian/Alaskan Native
Hispanic/Latino
White
Other

Health Insurance Information

Medicaid
Medicare
Kaiser Permanente
Other Private
No Insurance

Insurance Policy Number

Health Screening Questions  *Footnotes for precautions/contraindications are on other side of this document*

1. Are you sick today?  Yes* No
2. Do you have a serious allergy to food, a vaccine component, or latex?  Yes No
3. Have you ever had a serious reaction to a previous dose of vaccine or any medication?  Yes No
4. Have you had severe allergic reaction to any component of either the Pfizer-BioNTech or the Moderna vaccine?  Yes No
5. Are you pregnant, or is there a chance you may become pregnant in the next 14 days?  Yes No
6. Have you received any vaccinations in the last 14 days?  Yes No
7. Have you been ill with or recovered from a COVID infection or had antibody therapy in the past 3 months?  Yes No
8. 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

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

1A-Highest risk: Direct contact w COVID patients, LTC staff/residents
1B-Moderate Risk: EMS, Fire, Police, Corrections, HH/hospice workers, Dental, other first responders, funeral services, COVID response personnel, Health care workers with less direct contact with COVID-19 patients
2-Higher risk and essential workers: Age 65 or older, or Individuals: 1) With underlying health conditions; 2) In direct contact with the public; 3) Working in or serving people in high density settings; 4) Health care workers not included in Phase 1, and; 5) Who received the placebo in Clinical Trials.
3-General Public: Age 18-64 without high-risk conditions

Authorization to Administer COVID Vaccine

I have read or had explained to me, and I understand the risks and benefits of receiving the 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: [Public] [Private]
Prescribing Provider Name

Manufacturer

Dosage
Lot No.

Site:
RD RT LD LT

Date Administered

Administered by:
Name ___________________________ Title ___________________________

Rev. 12/21/2020
Precautions/Contraindications for vaccination

Triage of persons presenting for vaccination with either Pfizer-BioNTech or the Moderna COVID-19 vaccine

<table>
<thead>
<tr>
<th>MAY PROCEED WITH VACCINATION</th>
<th>PRECAUTION TO VACCINATION</th>
<th>CONTRAINDICATION TO VACCINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONDITIONS</td>
<td>CONDITIONS</td>
<td>CONDITIONS</td>
</tr>
<tr>
<td>• Immuno-compromising conditions</td>
<td>• Moderate/severe acute illness</td>
<td>• None</td>
</tr>
<tr>
<td>• Pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lactation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACTIONS</td>
<td>ACTIONS</td>
<td>ACTIONS</td>
</tr>
<tr>
<td>• Additional information provided</td>
<td>• Risk assessment</td>
<td>• N/A</td>
</tr>
<tr>
<td>• 15 minute observation period</td>
<td>• Potential deferral of vaccination</td>
<td></td>
</tr>
<tr>
<td>• 15 minute observations period if vaccinated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALLERGIES</td>
<td>ALLERGIES</td>
<td>ALLERGIES</td>
</tr>
<tr>
<td>• History of food, pet, insect, venom, environmental, latex, or other allergies not related to vaccines or injectable therapies</td>
<td>• History of severe allergic reaction (e.g., anaphylaxis) to another vaccine (not including either the Pfizer-BioNTech or the Moderna vaccine)</td>
<td>• History of severe allergic reaction (e.g., anaphylaxis) to any component of either the Pfizer-BioNTech or the Moderna vaccine</td>
</tr>
<tr>
<td>• History of allergy to oral medications (including the oral equivalent of an injectable medication)</td>
<td>• History of severe allergic reaction (e.g., anaphylaxis) to an injectable therapy</td>
<td></td>
</tr>
<tr>
<td>• Non-serious allergy to vaccines or other injectables (e.g., no anaphylaxis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Family history of anaphylaxis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Any other history of anaphylaxis that is not related to a vaccine or injectable therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACTIONS</td>
<td>ACTIONS</td>
<td>ACTIONS</td>
</tr>
<tr>
<td>• 30 minute observation period: Persons with a history of severe allergic reaction (e.g., anaphylaxis) due to any cause</td>
<td>• Risk assessment</td>
<td>• DO NOT VACCINATE</td>
</tr>
<tr>
<td>• 15 minute observation period: Persons with allergic reaction, but not anaphylaxis</td>
<td>• Potential deferral of vaccination</td>
<td></td>
</tr>
<tr>
<td>• 30 minute observation period if vaccinated</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regarding “Yes” answer to Question 7-Recent illness or antibody therapy. Vaccination should be deferred for 90 days as the circulating antibodies may interfere with vaccine response.