



COVID-19 VACCINATION SCREENING & ENCOUNTER FORM



DATE:

VDH Client ID#

Last Name		First Name		Middle Name		Birth Date ____ / ____ / ____	
Address (Not a PO Box)	Street _____						
	City _____		State _____		Zip _____		
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Race	<input type="checkbox"/> American Indian/Alaskan Native		<input type="checkbox"/> Asian		<input type="checkbox"/> Black or African American	
		<input type="checkbox"/> Hawaiian Native or Other Pacific Islander		<input type="checkbox"/> White		<input type="checkbox"/> Not Stated	
						Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	
Home Phone		Cell Phone		Email			

I consent to receive vaccination information or reminders by Text message Email

I hereby authorize the administration of the COVID-19 vaccine to myself or to the person named below for whom I am the legal representative. I have read or have had explained to me the COVID-19 Emergency Use Authorization fact sheet and understand the risks and benefits. I have had the opportunity to ask questions about this immunization. I believe the benefits outweigh the risks, and I accept full responsibility for any reactions that may result from my receipt of the immunization or the receipt of the immunization by the person named below for whom I am the legal representative. I agree that the immunization record may be shared as stated in the Notice of Privacy Practices, which includes sharing with health care providers and to support the application for payment by Medicare, Medicaid, or other third party payer. I request the third party payer to pay any authorized benefits to VDH on my behalf. The Notice of Deemed Consent for blood borne diseases has been explained to me and I understand it.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any VDH health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (HIV, as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the tests. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.
2. If you should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the tests.

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read the Notice of Privacy Practices from the Virginia Department of Health.

VACCINES ADMINISTERED		ICD-10 Z23		
Item Code	Lot Number/NDC	Route	Administration Site	Provider #
COVID-19-MOD (0.5 mL) Moderna		IM	<input type="checkbox"/> RA <input type="checkbox"/> LA	
Admin code (circle one) Moderna 1st dose 0001A 2nd dose 0002A				
COVID-19-PFR (0.3 mL) Pfizer		IM	<input type="checkbox"/> RA <input type="checkbox"/> LA	
Admin code (circle one) Pfizer 1st dose 0011A 2nd dose 0012A				

Patient, Parent/Legal Guardian, Person Acting in Loco Parentis -Printed Name _____ Signature _____ Date _____

Provider Printed Name _____ Signature _____ Date _____

COVID-19 PRE-VACCINATION SCREENING QUESTIONNAIRE

The following questions will help us determine if there is any reason we should not give you, or the person for whom you are the legal representative, the COVID-19 vaccination today. If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Please answer the following questions for the person being vaccinated:

1. Are you feeling sick today?

Yes No Don't know

2. Are you pregnant or do you plan to become pregnant?

Yes No Don't know

3. Are you breastfeeding?

Yes No

4. Have you ever received a dose of COVID-19 vaccine?

Yes No Don't know

If yes, which vaccine product? Pfizer Another product _____

5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?

Yes No Don't know

• Was the severe allergic reaction after receiving a COVID-19 vaccine?

Yes No Don't know

• Was the severe allergic reaction after receiving another vaccine or another injectable medication?

Yes No Don't know

6. Do you have a bleeding disorder or are you taking a blood thinner?

Yes No Don't know

7. Have you received passive antibody therapy as treatment for COVID-19?

Yes No

8. Are you immunocompromised or do you take a medicine that affects your immune system?

Yes No