Colorado COVID-19
Vaccine Screening and Administration Form

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

E X A M P L E 1 2 3

Please answer all questions as completely as possible.
*Please use only **black** ink to complete form.*

The administration record is on the reverse side of this document.

Please complete ALL the information below as accurately as possible. If you are completing this form for your minor child, do not use nick-names or abbreviations, except where allowed. All information will be kept confidential.

Patient/Child Last Name **Patient/Child First Name** **M.I.**

Date of Birth M M / D D / Y Y Y Y **Age** (years) **Age** (months) **Patient/Representative Daytime Phone Number** - -

If under 18 years of age please complete **Parent First Name** **Parent Last Name**

Address **Apt. Number**

City **County** **State**

Zip Code **E-mail Address**

Gender Identity ☐ F ☐ M ☐ Transgender Female/Feminine ☐ Transgender Male/Masculine ☐ Non-Binary ☐ Un-specified ☐ Decline to Provide

Are you Hispanic/Latin/a/o/x? ☐ Yes ☐ No ☐ Decline to Provide

Race(s) check all that apply ☐ American Indian/Alaskan Native ☐ Asian ☐ Black, African American ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ White ☐ Decline to Provide

Health Insurance **(OPTIONAL-INSURANCE NOT REQUIRED FOR VACCINATION)**

☐ Medicaid ☐ Medicare ☐ Kaiser Permanente ☐ United Healthcare ☐ Other Private ☐ No Insurance

Insurance Policy Number S E E R E V E R S E S I D E

Have you or your child received one dose or more doses of COVID-19 vaccine? ☐ Yes ☐ No ☐ Unsure

If yes, was one of them an omicron/bivalent vaccine dose? ☐ Yes ☐ No ☐ Unsure

	Health Screening Questions	Yes	No	Don't Know
1.	Are you or your child sick today or have a fever?			
2.	Have you or your child had an allergic reaction to polysorbate, polyethylene glycol, or a previous dose of COVID-19 vaccine?			
3.	Have you or your child ever had a serious allergic reaction (anaphylaxis) to another vaccine or any injectable medication?			
4.	Have you or your child had severe allergic reaction (anaphylaxis) to foods, pets, venom, environmental or oral medications?			
5.	Are you or your child immunocompromised?			
6.	Have you or your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) after receiving a vaccine?			
7.	Do you or your child have a history of Multisystem Inflammatory Syndrome known as MIS-C (in children) or MIS-A (in adults) after a COVID-19 infection?			
8.	Do you or your child have a history of myocarditis or pericarditis? (Especially males ages 12-29 years after receiving a dose of mRNA vaccine)			
9.	Do you or your child have a history of heparin-induced thrombocytopenia (HIT)?			
10.	Do you or your child have a history of COVID-19 disease (a positive COVID -19 test) within the past 3 months?			
11.	Have you or your child been vaccinated with mpox (Jynneos) vaccine in the last 4 weeks?			
12.	Have you or your child received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?			

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Patient/Child Last Name | **Patient/Child First Name** | **M.I.**

Date of Birth ___ / ___ / _____ (MM / DD / YYYY)

Age (years) **Age (months)**

Authorization to Administer COVID-19 Vaccine

I have read or had explained to me the Fact Sheet for Recipients and Caregivers for the use of the COVID-19 vaccine and understand the benefits and risks to me or my child of receiving this 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.

Signature of Patient/Parent/Legal Guardian/ Medical Durable Power of Attorney: ______________________________ **Date:** ______/______/________

STOP: DO NOT WRITE BELOW THIS LINE-FOR CLINIC STAFF ONLY

COVID/VFC PIN	Clinic Name
1062	Parker Pediatrics

Provider Type	Provider Name
☐ Public ☒ Private	Brian Stanga

Vaccine Manufacturer / Dosage

Pfizer

- ☐ Gray Cap - 0.3 ml/30 ug 12y+
- ☐ Orange Cap - 0.2 ml/10 ug 5y-11y
- ☐ Maroon Cap - 0.2 ml/3 ug 6m-4y

Moderna (crossed out)

- ☐ Dark Blue Cap - 0.5 ml/50 ug
- Dark Blue Cap - 0.25 ml/25 ug
- ☐ Dark Pink Cap/Yellow Label - 0.2 ml/10 ug

☐ ~~Novavax 0.5 ml~~

To assist healthcare providers, the COVID-19 vaccination schedule for people who are moderately or severely immunocompromised (Table 2) provides detailed age-specific guidance. However, the EUAs for Moderna and Pfizer-BioNTech COVID-19 vaccines allow healthcare providers flexibility for use of vaccine products, number of doses, dosage, and intervals between doses; alternative schedules within the parameters of the EUAs may be appropriate based on individual circumstances and clinical judgement. Interim Clinical Considerations for Use of COVID-19 Vaccines

Site: ☐ LD ☐ LT ☐ RD ☐ RT

Date Administered: ___ / ___ / _____ (MM / DD / YYYY)

Lot Number

Vial Expiration Date _____/_____/_______

Administered by

Name ______________________ Title ________

For vaccine administration guidance, including: timing, dosing, site selection, needle length and gauge, and administration procedures, please reference your standing orders or the CDC's Interim Clinical Considerations".

https://covid19.colorado.gov/vaccine-providers

https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

https://www.immunize.org/covid-19/

Please complete insurance information:

Insurance Carrier	☐ Aetna ☐ BCBS ☐ BHP ☐ Cigna ☐ CHP ☐ Cofinity ☐ CHN ☐ Hum ☐ MCD ☐ RKM ☐ Tricare ☐ UHC / UMR Other:
Policy Owner	
Policy Owner DOB	
Member ID	
Claims Mailing Address	