CLEAR CREEK COUNTY
Public & Environmental Health

VACCINE DOCUMENTATION/CONSENT FORM

I have been offered a copy of the Vaccine Information Statement(s) for the vaccines indicated below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request. I consent to inclusion of this immunization data in Colorado Immunization information System Registry for myself or on behalf of the person named below.

Signature of Patient/Guardian Date:

Patient Information			
First Name:	Last Name:		MI:
DOB:	Ph #	County:	
Home Address:			
City:	State:	Zip:	
Gender:	Race:	☐ Hispanic/Latino	
Preferred Language:		☐ Not Hispanic/Latino	
Allergies:			
Medications:			

Insurance Information		
Primary Insurance Co:		
Policy #:	Group #:	
Subscriber's Name:		Subscriber's DOB:
Subscriber's Address:		
Subscriber's Relationship to Patient:		

Screening Checklist for Contraindications to Vaccines

The following questions will help us determine which vaccines you, or your child may be given today. If you answer "yes" to any question, it does not necessarily mean you, or your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider for clarification.

Please answer all questions about the person to be vaccinated:

FOR INACTIVATED INJECTABLE INFLUENZA VACCINE:

	yes	no	don't know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain Barré syndrome?	☐	☐	☐
5. Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
6. Is the person to be vaccinated anxious about getting a shot today?	☐	☐	☐

FOR COVID-19 VACCINATION:

1.	Are you feeling sick today?	☐ Yes	☐ No	☐ Unknown
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.	How old will the person be on the day of vaccination? _____			
4.	Has the person to be vaccinated ever received a dose of COVID-19 vaccine? • If yes, which product was administered? ☐ Pfizer-BioTech ☐ Janssen (Johnson & Johnson) ☐ Another product ☐ Moderna ☐ Novavax _____ • How many doses of COVID-19 vaccine were previously administered? _____ • Did you bring the vaccination record card or other documentation?	☐ Yes ☐ Yes	☐ No ☐ No	☐ Unknown
5.	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
6.	Are you moderately or severely immunocompromised due to one or more of the medical conditions or receipt of immunosuppressive medications or treatments listed below? 1) Active treatment for solid tumor and 2)hematologic malignancies, 3) Receipt of solid-organ transplant and taking immunosuppressive therapy, 4) Receipt of CAR-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy), 5) Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome), 6) Advanced or untreated HIV infection, 7) Active treatment with high-dose corticosteroids (i.e., 20 mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory.	☐ Yes	☐ No	☐ Unknown
7.	Are you pregnant or considering becoming pregnant?	☐ 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
11.	Do you have a history of MIS-C or MIS-A (multisystem inflammatory syndrome in children or multisystem inflammatory syndrome in adults)?	☐ Yes	☐ No	☐ Unknown
12.	Have you recently received an orthopoxvirus vaccine within the last 4 weeks (e.g., JYNNEOS or ACAM2000)?	☐ Yes	☐ No	☐ Unknown