# COVID-19 VACCINE SCREENING FORM

County of San Luis Obispo Public Health Department
2191 Johnson Ave, San Luis Obispo, CA 93401
Phone: 805-781-5500 | Fax: 805-781-5543 | www.slopublichealth.org

Haga clic aqui para el formulario Español

2020-2021

## DEMOGRAPHIC INFORMATION

**Last Name:** _____ **First Name:** _____ **Middle Initial:** ___

**Street Address:** _____ **Mother's First Name:** _____

**City:** _____ **ZIP:** _____ **Gender:** ☐ Male ☐ Female ☐ Decline to state

**Phone (xxx-xxx-xxxx):** _____

**Birthdate (mm/dd/yyyy):** _____

**Email:** _____

**RACE (select 1):** ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islande ☐ Black or African-American ☐ White Other *(fill in below):* _____

**Ethnicity (select 1):** ☐ *HISPANIC OR LATINO* ☐ *NOT HISPANIC OR LATINO*

## INFORMATION

| | YES | NO | DON'T KNOW |
|---|---|---|---|
| **1.** Are you feeling sick today? | ☐ | ☐ | ☐ |
| **2.** Have you ever received a dose of COVID-19 vaccine? | ☐ | ☐ | ☐ |
| • If yes, which vaccine product did you receive and on what date(s): | | | |
| ☐ Pfizer Date(s): _____ ☐ Moderna Date(s): _____ ☐ Janssen (Johnson & Johnson) Date: _____ ☐ Another Product: _____ Date: _____ | | | |
| • Did you bring your vaccination record card or other documentation? *(yes/no)* | ☐ | ☐ | |
| **3.** Have you ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)* | | | |
| • A component of a COVID-19 vaccine, including either of the following: | | | |
| o Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures | ☐ | ☐ | ☐ |
| o Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids | ☐ | ☐ | ☐ |
| • A previous dose of COVID-19 vaccine | ☐ | ☐ | ☐ |
| **4.** Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)* | ☐ | ☐ | ☐ |

**5.** Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer)
- ☐ Take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of herparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ Had a positive test for COVID-19 or been told by a doctor that you had Covid-19

I, the undersigned, certify that all of the above information is correct to the best of my knowledge.

_____ _____ _____

Signature Date Relationship to person named on this form:

# COVID-19 VACCINE SCREENING FORM

2020-2021

**County of San Luis Obispo Public Health Department**
*2191 Johnson Ave, San Luis Obispo, CA 93401*
*Phone: 805-781-5500 | Fax: 805-781-5543 | www.slopublichealth.org*

## Acknowledgment of Vaccine Information, Privacy Practices, and Self-Attestation

☐ I have read or had explained to me the ***COVID-19 Vaccine Information Statement***. I have had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and request that it to be given to me or to the person for whom I am authorized to make this request.

Link for Pfizer BioNTech ***COVID-19 Vaccine Information Statement***: *https://www.fda.gov/media/144414/download*

*Link for Moderna* ***COVID-19 Vaccine Information Statement:***
*https://www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-recipients.pdf*

*Link for Janssen (J&J)* ***COVID-19 Vaccine Information Statement:*** *https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/COVID-19/JnJ_factsheet.pdf*

---

☐ I hereby acknowledge that I have been offered or have received a copy of San Luis Obispo County Health Agency's Notice of Private Practices. I further acknowledge that a copy of the current notice is posted in the reception area of each clinic and I will be offered a copy.

Signature (Patient) Date

Signature (Parent or Guardian) Date

Name - PLEASE PRINT

Name - PLEASE PRINT

---

**Phone Consent / Video Call Consent for 12-17 y/o**

Witness Name / Signature Date

Parent / Guardian Name

~Do Not Write Below This Line~

| Medical Evaluation By: | Administered By: | Injection Site: |
|---|---|---|
| Print Name | Print Name | |
| Full Signature & suffix | Full Signature & suffix | |

Vaccinate? Yes ☐ No ☐

Vaccine Lot

*[Affix Label Here]*