COVID-19 VACCINATION SCREENING & ENCOUNTER FORM

VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

DATE: VDH Client ID#

Last Name	First Name	Middle Name	Birth Date
			____/____/____

Address (Not a PO Box)

Street_____

City_____ **State**_____ **Zip** _____

Gender ☐M ☐F	Race	☐American Indian/Alaskan Native ☐Asian ☐Black or African American ☐Hawaiian Native or Other Pacific Islander ☐White ☐Not Stated	Hispanic/Latino ☐Yes ☐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 vaccination 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, and other third party payor. 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 test. 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	Lot Number/NDC	Route	Administration Site	Provider #
COVID-19 Vaccine **Moderna** (0.5 mL)		IM	☐ RA ☐ LA	
Admin (circle one) **Moderna** 1st dose 2nd dose				
COVID-19 Vaccine **Pfizer** (0.3 mL)		IM	☐ RA ☐ LA	
Admin (circle one) **Pfizer** 1st dose 2nd dose				

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

Provider Printed Name Signature Date

CHS-2b_COVID (rev. 01/08/21)

SCREENING QUESTIONNAIRE ON BACK

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. **Have you had a positive COVID-19 test?**

   ☐ Yes ☐ No ☐ Don't know

   If yes, are you currently in isolation?

   ☐ Yes ☐ No ☐ Don't know

2. **Are you feeling sick today?**

   ☐ Yes ☐ No ☐ Don't know

3. **Are you pregnant or do you plan to become pregnant?**

   ☐ Yes ☐ No ☐ Don't know

4. **Are you breastfeeding?**

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No ☐ Don't know

   If yes, which vaccine product? ☐ Pfizer ☐ Another product _____

6. **Have you received a vaccine in the last 14 days?**

   ☐ Yes ☐ No ☐ Don't know

7. **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

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

   ☐ Yes ☐ No ☐ Don't know

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

   ☐ Yes ☐ No

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

    ☐ Yes ☐ No