The Corvallis Clinic™

Patient Consent Form and Screening Checklist for Contraindications to the COVID-19 Vaccine

For patients (both children and adults) to be vaccinated:

The following questions will help us determine if there is any reason we should not give you or your child a COVID-19 vaccination 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 to explain it.

	Yes	No	Don't Know
1. How old is the person to be vaccinated? _____			
2. Are you feeling sick today?	☐	☐	☐
3. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer-BioNTech ☐ Janssen *(Johnson & Johnson)* ☐ Another Product ☐ Moderna ☐ Novavax _____			
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	☐	☐	
4. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.*	☐	☐	☐
5. Have you received a COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. 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	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. 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.)*	☐	☐	☐
8. Check all that apply to you:			

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months?
- ☐ Vaccinated with monkeypox vaccine in the last 4 weeks?

Adapted with appreciation from the Centers for Disease Control and Prevention (CDC) screening checklist for COVID-19 vaccines. https://www.cdc.gov/vaccines/covid-19/downloads/pre-vaccination-screening-form.pdf

UPDATED 04/27/2023

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By signing below, you give consent to be vaccinated by The Corvallis Clinic staff named below and acknowledge that you have read the emergency use authorization (EUA) fact sheet for the applicable COVID-19 vaccine and understand the risks and benefits.

Patient _____/_____/_____/_____

Name (print) *DOB* *Signature* ***(patient or legal guardian)*** *Today's Date*

CLINIC USE ONLY

Mfr.	Vaccine	Dose	Site	Location	EUA Date	Lot # / Exp. Date
Monovalent Vaccines						Place vaccine sticker below **OR** fill in: **Lot #** _____ **Exp.** _____
novavax	**COVID-19 - Monovalent** **12+ (Royal Blue Cap)**	**0.5 mL** (5/50 mcg)	Deltoid | Vastus Lateralis	R | L	10/19/2022	
Bivalent Vaccines						
moderna	**COVID-19 - Bivalent** **12+ (Grey Borders)**	**0.5 mL** (50 mcg)	Deltoid | Vastus Lateralis	R | L	04/18/2023	
moderna	**COVID-19 - Bivalent** **6m-11yr (Grey Borders)**	**0.25 mL** (25 mcg)	Deltoid | Vastus Lateralis	R | L	04/18/2023	
moderna	**COVID-19 - Bivalent** **6m-5yr (Yellow Borders)**	**0.2 mL** (10 mcg)	Deltoid | Vastus Lateralis	R | L	04/18/2023	
Pfizer	**COVID-19 - Bivalent** **12+ (Grey Top & Borders)**	**0.3 mL** (30 mcg)	Deltoid | Vastus Lateralis	R | L	04/18/2023	
Pfizer	**COVID-19 - Bivalent** **5-11yr (Orange Top)**	**0.2 mL** (10 mcg)	Deltoid | Vastus Lateralis	R | L	04/18/2023	
Pfizer	**COVID-19 - Bivalent** **6m-4yr (Maroon Top)**	**0.2 mL** (3 mcg)	Deltoid | Vastus Lateralis	R | L	04/18/2023	

Per pt's answers to their screening questions, they were advised to stay for ⟶ **15 Minutes / 30 Minutes**

Administered by _____/_____/_____

Name (print) *Signature* *Today's **Date** & **Time***

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