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?

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 09/08/2022

The Corvallis Clinic™

***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 |
|---|---|---|---|---|---|---|
| **Primary Series** | | | | | | |
| janssen | **COVID-19 - Monovalent 18+** | **0.5 mL** (5x1010) | Deltoid \| Vastus Lateralis | R \| L | 05/05/2022 | Place vaccine sticker below **OR** fill in:<br>**Lot #** _____<br>**Exp.** _____ |
| novavax | **COVID-19 - Monovalent 12+ (Royal Blue Cap)** | **0.5 mL** (5/50 mcg) | Deltoid \| Vastus Lateralis | R \| L | 08/19/2022 | |
| moderna | **COVID-19 - Monovalent 12+ (Light Blue Borders)** | **0.5 mL** (100 mcg) | Deltoid \| Vastus Lateralis | R \| L | 08/31/2022 | |
| moderna | **COVID-19 - Monovalent 6-11yr (Purple Borders)** | **0.5 mL** (50 mcg) | Deltoid \| Vastus Lateralis | R \| L | 06/17/2022 | |
| moderna | **COVID-19 - Monovalent 6m-5yr (Magenta Borders)** | **0.25 mL** (25 mcg) | Deltoid \| Vastus Lateralis | R \| L | 06/17/2022 | |
| Pfizer | **COVID-19 - Monovalent 12+ (Grey Top)** | **0.3 mL** (30 mcg) | Deltoid \| Vastus Lateralis | R \| L | 08/31/2022 | |
| Pfizer | **COVID-19 - Monovalent 5-11yr (Orange Top)** | **0.2 mL** (10 mcg) | Deltoid \| Vastus Lateralis | R \| L | 06/28/2022 | |
| Pfizer | **COVID-19 - Monovalent 6m-4yr (Maroon Top)** | **0.2 mL** (3 mcg) | Deltoid \| Vastus Lateralis | R \| L | 06/28/2022 | |
| **Booster Dose** | | | | | | |
| moderna | **COVID-19 - Bivalent 18+ (Grey Borders)** | **0.5 mL** (50 mcg) | Deltoid \| Vastus Lateralis | R \| L | 08/31/2022 | |
| Pfizer | **COVID-19 - Bivalent 12+ (Grey Top & Borders)** | **0.3 mL** (30 mcg) | Deltoid \| Vastus Lateralis | R \| L | 08/31/2022 | |
| Pfizer | **COVID-19 - Monovalent 5-11yr (Orange Top)** | **0.2 mL** (10 mcg) | Deltoid \| Vastus Lateralis | R \| L | 06/28/2022 | |

**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***

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 09/08/2022