Colorado COVID-19
Vaccine Administration and Screening Form

Please print neatly in capital letters as shown in the example below

E X A M P L E 1 2 3

Please answer all questions as completely as possible

Use reverse side for notes

Personal Information. Provide information as completely as you can. All information will be kept confidential.

Last Name | **First Name** | **MI** | **Gender** ☐ M ☐ F

Street No. or PO Box | **Street Name** | **Apt. Number**

City | **County** | **State**

Zip Code | **Phone** ( ) - | **E-mail**

Date of Birth M M / D D / Y Y Y Y

Race/Ethnicity (Check all that apply)

☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino
☐ Black, African American ☐ American Indian/Alaskan Native ☐ White
☐ Other

Health Insurance Information

☐ Medicaid ☐ Medicare ☐ Kaiser Permanente ☐ Other Private ☐ No Insurance

Insurance Policy Number

Health Screening Questions ***Footnotes for precautions/contraindications are on other side of this document***

	Yes*	No
1. Are you sick today?	☐	☐
2. Do you have a serious allergy to food, a vaccine component, or latex?	☐	☐
3. Have you ever had a serious reaction to a previous dose of vaccine or any medication?	☐	☐
4. Have you had severe allergic reaction to any component of either the Pfizer-BioNTech or the Moderna vaccine?	☐	☐
5. Are you pregnant, or is there a chance you may become pregnant in the next 14 days?	☐	☐
6. Have you received any vaccinations in the last 14 days?	☐	☐
7. Have you been ill with or recovered from a COVID infection or had antibody therapy in the past 3 months?	☐	☐
8. Do you have any of the following illnesses or conditions? Chronic lung disease (including asthma), heart disease, diabetes, brain, spinal cord or muscle illness that causes swallowing or lung problems, problems with the immune system caused by medications and/or HIV, kidney disease, liver disease, blood disorders	☐	☐

Please identify Phase Category you are in (please choose only one)

☐ **1A**-Highest risk: Direct contact w COVID patients, LTC staff/residents

☐ **1B**-Moderate Risk: EMS, Fire, Police, Corrections, HH/hospice workers, Dental, other first responders, funeral services, COVID response personnel, Health care workers with less direct contact with COVID-19 patients

☐ **2**-Higher risk and essential workers: Age 65 or older, or Individuals: 1) With underlying health conditions; 2) In direct contact with the public; 3) Working in or serving people in high density settings; 4) Health care workers not included in Phase 1, and; 5) Who received the placebo in Clinical Trials.

☐ **3**-General Public: Age 18-64 without high-risk conditions

Authorization to Administer COVID Vaccine

I have read or had explained to me, and I understand the risks and benefits of receiving the vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I hereby release this provider, its employees and its volunteers from any liability for any results which may occur from the administration of this vaccine.

Patient, Parent/Guardian Signature: _____ Date: _____

STOP - DO NOT WRITE BELOW THIS LINE

COVID/VFC PIN

Clinic Name | Provider Type: ☐ Public ☐ Private

Prescribing Provider Name

Manufacturer: ☐ PFR (Pfizer) ☐ AstraZeneca/Oxford Biomedica ☐ Moderna ☐ SP/GSK ☐ J&J

Dosage: ☐ 0.3 ml ☐ 0.5 ml

Lot No.

Site: ☐ RD ☐ RT ☐ LD ☐ LT

Date Administered: M M / D D / Y Y Y Y

Administered by:

Name _____ Title _____

Rev. 12/21/2020