STATE OF ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

COVID-19 Immunization Form

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|  |  | Privacy Practice Notification Received? YesNo |
| Date: |  | Emergency Use Authorization Fact Sheet received? YesNo |

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| **PARTICIPANT’S INFORMATION** | | | | | | | | | | | | | |
| First Name | | |  | | | Middle Initial | | | | Last Name | | |
| Gender | | | MaleFemale Other | | | | | | | | | | |
| Date of Birth | | |  | | | Age | | | | | | | |
| Mailing Address: Street, City, State, Zip | | |  | | | | | | | | | | |
| What City/Village do you currently live in? | | |  | | | | | | | | | | |
| Cell Phone | | |  | | | | | | Home Phone | | | | |
| Race  Check all that apply | | | American Indian/Alaska Native | | | | | Asian | | | White Other | | |
| Black/African American | | | | Hawaiian/Pacific Islander  Decline | | | | | | |
| Hispanic? | | | Yes | No Decline | | | | | | | |
|  | | Insurance Type | Medicaid MedicareTricareOtherPrivate InsuranceUninsured | | | | | | | | | | |
|  | **Do you have any of the following Health conditions?** | | **Asthma - Serious Heart Condition - Liver Disease - Chronic Lung Disease**  **Diabetes - Severe Obesity - Immunocompromised**  Yes No Unknown | | | | | | | | | | |
| **Occupation**  Construction, Landscaping, Other trades  First Responders-Fire, Police, EMT  Healthcare-Direct Patient contact  Healthcare-No direct Patient contact  Office worker-manager, supervisor, employee, clerical  Oil Industry  Plant workers, Manufacturing, Machine Operators, and assemblers  School employee or contractor | | | | | Seafood Industry  Service**-**Entertainment  Service-Restaurants, Bars, Catering, Fast Food  Service-Retail, cosmetology, massage, elective services  Service-Transportation  Service-Tourism  Skilled Agriculture  Other | | | | | | | | |
|  | | | | | | | | | | | | | |
| **PARENT/GUARDIAN OR AUTHORIZED PERSON INFORMATION** | | | | | | | | | | | | | |
| Parent/Guardian First and Last Name | | |  | | | | | | | | | | |
| Cell phone or home phone number | | |  | | | | | | | | | | |
| I am currently | | | Employed Unemployed  Self Employed | | | | | | | | | | |
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| **COVID-19 Vaccine Screening Questions** | | | | **Yes** | | **No** | | **Don’t Know** | |
| 1. | Are you feeling sick today? |  |  | |  | |  | |  |
| 2. | Have you ever received a dose of a COVID-19 vaccine? If Yes, which vaccine product? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | |  | |  | |  |
| 3. | Do you have any allergies, such as to medications, food, or vaccine components? |  |  | |  | |  | |  |
| 4. | Have you ever had a serious reaction to a vaccine or any injectable? |  |  | |  | |  | |  |
| 5. | Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? |  |  | |  | |  | |  |
| 6. | Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? |  |  | |  | |  | |  |
| 7. | Do you have cancer, leukemia, HIV/AIDs, or other immune system problem? |  |  | |  | |  | |  |
| 8. | Do you have a bleeding disorder or are you taking a blood thinner? |  |  | |  | |  | |  |
| 9. | Have you received any other vaccines in the past 14 days? |  |  | |  | |  | |  |
| 10. | For women: Are you pregnant or could become pregnant in the next month or currently breastfeeding? |  |  | |  | |  | |  |

**Please read and sign if you agree on the following page.**

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| **Informed Consent:** *Please read and sign.* |
| My signature below indicates that:   * I have voluntarily chosen to receive the vaccination and consent to the administration. * I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient or am authorized to consent on behalf of the client. * I have read, or have had read to me, the Vaccine Information Statement(s) (“VIS”) or Emergency Use Authorization (“EUA”) provided for the vaccine(s) to be administered. * I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. * I understand the benefits and risks of the vaccine(s). * I will immediately alert the provider of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine. * I understand I should remain in the area for 15 minutes after the vaccination for observation or 30 minutes if I have any history of severe allergic reaction or anaphylaxis. |

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|  | | |  | | | | | | | | | | | | | |  | |  | | | | |
|  | | Participant/Guardian/Authorized Representative Signature | | | | | | | | | | | |  | | | | Date | | | | |
|  | |  | | | | | | | | | | | |  | | | |  | | | | |
| **OFFICE USE ONLY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CL 12 Primary TP 02 Secondary TP Codes 19 526  Client has Medicaid TP 000547 Purpose of Visit (PV): Immunizations** (V07.9) **.**  This is a Health Center or Individual encounter (Do not use TP Codes 19 and 526) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Vaccine** (CVX) | | | | | | | | | **1st/2nd dose** | | | **VFC/AVAP** | **Admin Site** | | | **Lot #** | | | | | **Manufacturer** | | | | | | **EUA Fact Sheet Date** | | |
| **Pfizer-BioNTech COVID-19 vaccine 0.3mL** (208) | | | | | | | | | |  | V07 | | |  | | |  | | | | | **PFR** | | | | | | |  | |
| **Moderna COVID-19 vaccine 0.5 mL** (207) | | | | | | | | | |  | V07 | | |  | | |  | | | | | **MOD** | | | | | | |  | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Provider name (print)** | | | | | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (PRV) | | | | | | | | | | | | | | | | | | | |
| **Provider name (signature)** | | | | | | | |  |  | | | | | | | | | | | | | | |
| **Additional POVs (PV)** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |

🞏 Refer to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (V68.81)

**Problem List Notes** (PL V14.7 “Adverse Event COVID-19 [Manufacturer]”)

🞏 Adverse Event \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 VAERS Report completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Adverse Event Type 🞏 Local 🞏 Syncope 🞏Anaphylaxis**

**\*(If there was an adverse event, an event type must be selected.)**

🞏 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**POD Location**       (OLOC)

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| **Administration Sites** | |
| Left Deltoid IM | LDI |
| Right Deltoid IM | RDI |

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Arrival Time \_\_\_\_\_\_\_\_\_\_**

**Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exit Time \_\_\_\_\_\_\_\_\_\_**

**Health Center\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AT \_\_\_\_\_\_\_\_\_\_** TT**\_\_\_\_\_\_**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**