Colorado COVID-19
Vaccine Screening and Administration Form

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

E X A M P L E 1 2 3

Please answer all questions as completely as possible.
*Please use only **black** ink to complete form.*

The administration record is on the reverse side of this document.

Please complete ALL the information below as accurately as possible. If you are completing this form for your minor child, do not use nick-names or abbreviations, except where allowed. All information will be kept confidential.

Patient/Child Last Name | Patient/Child First Name | M.I.

Date of Birth (M M / D D / Y Y Y Y) | Age (years) | Age (months) | Patient/Representative Daytime Phone Number

If under 18 years of age please complete Parent First Name | Parent Last Name

Address | Apt. Number

City | County | State

Zip Code | E-mail Address

Gender Identity ☐ F ☐ M ☐ Transgender Female/Feminine ☐ Transgender Male/Masculine ☐ Non-Binary ☐ Un-specified ☐ Decline to Provide

Are you Hispanic/Latin/a/o/x? ☐ Yes ☐ No ☐ Decline to Provide

Race(s) check all that apply
☐ American Indian/Alaskan Native ☐ Black, African American ☐ Other ☐ Decline to Provide
☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White

Health Insurance (OPTIONAL-INSURANCE NOT REQUIRED FOR VACCINATION)
Medicaid ☐ Medicare ☐ Kaiser Permanente ☐ United Healthcare ☐ Other Private ☐ No Insurance ☐

Insurance Policy Number

If you have already received your Primary Dose(s) of a COVID-19 vaccine, please tell us which vaccine(s) you received and the date(s) of vaccination.

Dose(s) received: Dose 1: Vaccine Brand_____ Vaccination Date _____/_____/_____ | Dose 2: Vaccine Brand_____ Vaccination Date _____/_____/_____

If you have already received more than two (2) doses of a COVID-19 vaccine, please tell us which additional dose(s) you received, the vaccine(s), and the date(s) of vaccination.

Additional Dose received for High Risk Conditions : Vaccine Brand_____ Vaccination Date _____/_____/_____

Booster Dose: Vaccine Brand_____ Bivalent(Omicron): Yes / No Vaccination Date _____/_____/_____

	Health Screening Questions	Yes	No	Don't Know
1.	Are you or your child sick today or have a fever?			
2.	Have you or your child had an allergic reaction to polysorbate, polyethylene glycol, or a previous dose of COVID-19 vaccine?			
3.	Have you or your child ever had a serious allergic reaction (anaphylaxis) to another vaccine or any injectable medication?			
4.	Have you or your child had severe allergic reaction (anaphylaxis) to foods, pets, venom, environmental or oral medications?			
5.	Do you or your child have a bleeding disorder, are on long-term aspirin therapy, or take other blood thinners?			
6.	Have you or your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) after receiving a vaccine?			
7.	Have you received any dermal fillers (Juvaderm®, Restylane®, etc.)? (only applies to mRNA vaccines)			
8.	Do you have a history of blood clots or have risk factors for developing blood clots? (Janssen vaccine only, applies to females ages 18-49)			
9.	Do you or your child have a history of myocarditis or pericarditis? (Especially males ages 12-29 years after receiving a dose of mRNA vaccine)			
10.	Do you or your child have a history of heparin-induced thrombocytopenia (HIT)?			
11.	Do you or your child have a history of Multisystem Inflammatory Syndrome known as MIS-C (in children) or MIS-A (in adults) after a COVID-19 infection?			
12.	Are you or your child immunocompromised? (See additional dose section on next page)			

Continued on Next Page

Patient/Child Last Name

Patient/Child First Name

M.I.

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

Age (years)

Age (months)

Primary Dose : 1 ☐ 2 ☐ 3 ☐

Booster Dose: ☐

Authorization to Administer COVID-19 Vaccine

I have read or had explained to me the Fact Sheet for Recipients and Caregivers for the use of the COVID-19 vaccine and understand the benefits and risks to me or my child of receiving this 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.

Signature of Patient/Parent/Legal Guardian/
Medical Durable Power of Attorney: _____ Date: _____/_____/_____

STOP: DO NOT WRITE BELOW THIS LINE-FOR CLINIC STAFF ONLY

COVID/VFC PIN

Provider Type ☐ Public ☐ Private

Clinic Name

Provider Name

Brand Name (if available)

Lot Number

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

Pfizer *Primary Series* (ages 12 years and older) Primary Dose ☐ 0.3 ml	**Pfizer (*Orange Cap*)** (ages 5 - 11 years) Pediatric Primary and Booster Dose ☐ 0.2 ml	**Pfizer (*Maroon Cap*)** (ages 6 mo. - 4 years) Pediatric Primary Dose ☐ 0.2 ml	**Bivalent Pfizer Booster** (ages 12 years and older) Booster Dose ***ONLY*** ☐ 0.3 ml
Moderna *Primary Series* (ages 12 years and older) Primary Dose ☐ 0.5 ml	**Moderna *Primary Series*** (ages 6 - 11 years) Primary Dose ☐ 0.5 ml	**Moderna *(magenta border)*** (ages 6 mo. - 5 years) Pediatric Primary Dose ☐ **0.25 ml**	**Bivalent Moderna Booster** (ages 18 years and older) Booster Dose ***ONLY*** ☐ 0.5 ml
J&J (Janssen) (ages 18 years and older) Primary Dose ☐ 0.5 ml Booster Dose ☐ 0.5 ml	**Novavax** (ages 12 years and older) Primary Dose ☐ 0.5 ml		

Vial Expiration Date _____/_____/_____

Site ☐ LD ☐ LT ☐ RD ☐ RT

Administered by

Name _____ Title _____

For vaccine administration guidance, including: timing, dosing, site selection, needle length and gauge, and administration procedures, please reference your standing orders or the CDC's Interim Clinical Considerations".

https://covid19.colorado.gov/vaccine-providers

https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

https://www.immunize.org/covid-19/