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To hope and healing.

Juvenile Patient SARS-COV-2 Vaccination 2020-2021 Screening & Administration

Name:	ID#:	DOB:
Date/Time:	Allergies:	Gender:

Screening Questions: **Yes** **No**

1. Do you want a SARS-COV-2 vaccination? (sign refusal or consent below)....................... ☐ ☐
2. Are you, or could you be pregnant, or breastfeeding?.. ☐ ☐
3. Do you feel sick today? Fever, chills, headache, sore throat, muscle pain, congestion/runny nose, shortness of breath/difficulty, breathing, nausea, diarrhea, cough, new loss of taste or smell? .... ☐ ☐
4. Have you received monoclonal antibodies or convalescent plasma for treatment of COVID-19 within the last 90 days?.. ☐ ☐
5. Do you have a bleeding disorder or are on a blood thinner? .... ☐ ☐
6. Are you immunocompromised or on a medicine that affects your immune system?.......... ☐ ☐
7. Have you had any other vaccine in the previous 14 days?... ☐ ☐
8. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to any vaccine or component of this vaccine?.. ☐ ☐
9. Is patient high risk per CDC guidelines below? .... ☐ ☐
10. Have you ever had a thrombosis (blood clot) or thrombocytopenia (low platelets)……….. ☐ ☐
11. If female, are you between the ages of 18-50? ……………………………………………… ☐ ☐

*If any question 2-8 are yes: **DO NOT VACCINATE,** refer to provider for review / orders.*
If 10 or 11 are yes and offering Janssen vaccine: review risk factors for TSS and offer alternative vaccine if available.

High Risk Individuals

Adults ≥ 65 years, chronic pulmonary (including asthma), cardiovascular (excluding isolated hypertension), renal, hepatic, neurologic, hematologic, metabolic (including diabetes mellitus), immunocompromised due to any cause (including HIV and medications), obese adults (BMI ≥ 40)

☐ **Consent for Vaccination:**

I state that the above is true and complete to the best of my knowledge. I reviewed the Fact Sheet for Recipients and have been given opportunity to ask questions**.** I understand the benefits and risks of the vaccine, and ask that the vaccine be given to me. I understand that this is a 2-dose vaccination series and I will need to have a second vaccine in 21 or 28 days.

I certify that I am: (a) the patient and at least 16 years of age, medically emancipated, living separate and apart from my parents or guardians, managing my own financial affairs, no parent or guardian of mine is liable for my medical or dental care, and I am legally authorized to sign this consent and make the decision to receive this vaccination for myself; (b) the legal guardian of the patient and confirm that the patient is at least 16 years of age; or (c) authorized to consent for vaccination for the patient named above. I hereby give my consent to Wellpath or its agents to administer the COVID-19 vaccine.

Patient/Parent/Guardian Signature: ____________________________________ Date: ________________

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Name:	ID#:	DOB:
Date/Time:	Allergies:	Gender:

☐ Refusal for Vaccination:

I have been given the opportunity to be vaccinated against this infection at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring COVID-19. If, during the season for which the CDC recommends administration and vaccination supplies remain, I may change my mind and receive the vaccine.

I certify that I am: (a) the patient and at least 16 years of age, medically emancipated, living separate and apart from my parents or guardians, managing my own financial affairs, no parent or guardian of mine is liable for my medical or dental care, and I am legally authorized to sign this consent and make the decision to refuse this vaccination for myself; (b) the legal guardian of the patient and confirm that the patient is at least 16 years of age; or (c) authorized to consent for vaccination for the patient named above. I DO NOT give my consent to Wellpath or its agents to administer the COVID-19 vaccine.

Patient/Parent/Guardian Signature: ____ Date: _________________

Provider Review and Order:

☐ I have reviewed the above screening and consent/declination

Orders: Administer SARS-COV2 Vaccine- per CDC recommendation repeat x1 per manufactures recommended vaccine schedule, record vaccination in state immunization registry and in patient medical record.

☐ Pfizer-BioTech COVID-19 Vaccine 0.3 mL IM; repeat x 1 in 21 days (age 12+)

☐ Moderna COVID-19 Vaccine 0.5ml IM; repeat x 1 in 28 days (age 18+)

☐ Janssen COVID-19 Vaccine 0.5ml (age 18+)

☐ Other: ____

Provider signature:___________________________________ Date:_______________

Vaccine Administration Dose 1:

Brand Name: ______________________ Manufacturer:_______________
Lot Number:________________________ Expiration Date: ___________________
Site administered: ☐ Right Deltoid ☐ Left Deltoid ☐ Right Thigh ☐ Left Thigh
☐ Printed vaccination card provided to patient
☐ Recorded in State Immunization Registry
☐ Scheduled and instructed to return for 2nd vaccine on ______________

Nurse Signature:_____________________________________ Date: ______________

Vaccine Administration Dose 2: *(Must be same manufacturer as dose 1)*

Brand Name: ______________________ Manufacturer:_______________
Lot Number:________________________ Expiration Date: ___________________
Site administered: ☐ Right Deltoid ☐ Left Deltoid ☐ Right Thigh ☐ Left Thigh
☐ Printed vaccination card provided to patient
☐ Recorded in State Immunization Registry

Nurse Signature:_____________________________________ Date: ______________