Colorado COVID-19
Vaccine Screening and Administration Form

Please print neatly in capital letters as shown in the example below	*Please answer all questions as completely as possible*	***Health Screening Questions and the administration record are on reverse side of this document*
EXAMPLE 123		

Last Name **First Name** **MI**

Date of Birth (M M / D D / Y Y Y Y) **Home Address or Post Office Box**

Apt. Number **City** **County**

State **Zip Code** **Phone** ( ) - -

E-mail

Gender Identity

☐ Female ☐ Male ☐ Transgender Female/Feminine ☐ Transgender Male/Masculine ☐ Non-Binary ☐ Un-specified ☐ Decline to Provide

Race(s) check all that apply

☐ American Indian/Alaskan Native ☐ Asian ☐ Black, African American ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ White ☐ Decline to Provide

Ethnicity

☐ Hispanic/Latin/a/o/x ☐ Non-Hispanic/Latin/a/o/x ☐ Decline to Provide

Health Insurance Information (OPTIONAL-INSURANCE NOT REQUIRED FOR VACCINATION)

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

Insurance Policy Number

Have you already received a COVID vaccine? ☐ Y ☐ N **When? (Date)** _____ **Brand?** _____

Please identify your Phase Category (please choose only one)

☐ **1A. High-risk HCWs and LTC.**

☐ **1B.1-Moderate risk HCWs, age 70 +, and first responders**

☐ **1B.2-Ages 65-69, PK-12 educators and child care workers in licensed child care programs, continuity of state government:** 1) Child care workers in licensed child care programs 2) Teachers (full-time and substitutes) bus, food, counselors, administrative, safety and other school support services offered inside the school; 3) Select members of the Executive and Judicial branches of state government

☐ **1B.3 a. People age 60 and older, Frontline essential workers in grocery and agriculture:** workers who cannot maintain physical distance at their place of employment, work in close contact with many people, especially indoors and in places with poor ventilation: meatpacking workers, grocery store workers, and agricultural processing workers

☐ **1B.3 b. People age 16-59 with 2 or more high risk conditions: Check all that apply:**

- ☐ Cancer-currently receiving treatment or treated within the last month;
- ☐ Chronic kidney disease
- ☐ COPD
- ☐ Diabetes Mellitus (type 1 and 2)
- ☐ Down Syndrome
- ☐ Specific heart conditions:
  - ☐ heart failure,
  - ☐ cardiomyopathies or coronary artery disease,
  - ☐ severe valvular/congenital heart disease
- ☐ Obesity (BMI ≥ 30 kg/m²)
- ☐ Pregnancy
- ☐ Sickle cell disease
- ☐ Solid organ transplant
- ☐ People with disabilities that prevent them from wearing a mask
- ☐ Individuals with disabilities who require direct care in their home

☐ **1B.4 People age 50 and older; People who cannot maintain physical distance at their place of employment or who work in close contact indoors with many people or work in places with poor ventilation:**

Student-facing higher education employees
Frontline essential workers in:
- Food/restaurant services
- Manufacturing
- USPS
- Public transit and specialized transportation
- Public Health
- Human Services
- Direct Care providers for Coloradans experiencing homelessness

Frontline essential journalists
Faith leaders
Continuity of local government
Continuation of operations for state government
Adults who received a placebo during COVID vaccine clinical trials

☐ People 16-49 with one high risk conditions listed in 1.B.3 b or below:
- ☐ Asthma (moderate to severe)
- ☐ Cerebrovascular disease
- ☐ Cystic fibrosis
- ☐ Hypertension or high blood pressure
- ☐ Immunocompromised due to blood or bone marrow transplant
- ☐ Immune deficiencies
- ☐ HIV
- ☐ Use of corticosteroids or other immune weakening medicines
- ☐ Neurologic conditions (dementia)
- ☐ Liver disease
- ☐ Pulmonary fibrosis (damaged or scarred lung tissue)
- ☐ Thalassemia (a type of blood disorder)

☐ **2. General Public:** Any Coloradan not included in the other phases because of a lower risk of exposure or are less likely to have severe outcomes to COVID-19 disease.

Last Name | First Name | MI

Date of Birth (M M / D D / Y Y Y Y)

Dose Number 1 ☐ 2 ☐

Health Screening Questions		Yes	No
1.	Are you sick today?	☐	☐
2.	Have you ever had an allergic reaction to polysorbate, polyethylene glycol, or a previous dose of COVID-19 vaccine? ^*	☐	☐
3.	Have you ever had a serious allergic reaction (anaphylaxis) to another vaccine or any injectable medication? #	☐	☐
4.	Have you had severe allergic reaction (anaphylaxis) to foods, pets, environmental or oral medications?	☐	☐
5.	Are you pregnant or breastfeeding?	☐	☐
6.	Have you received any vaccinations in the last 14 days?	☐	☐
7.	Have you received any dermal fillers (Juvaderm®, Restylane®, etc.)? (only applies to mRNA vaccines)	☐	☐
8.	Have you been ill with or recovered from a confirmed COVID infection within the past 3 months?	☐	☐
9.	Have you had convalescent plasma or monoclonal antibodies as part of COVID-19 treatment in the past 3 months?	☐	☐

Authorization to Administer COVID-19 Vaccine

I have read or had explained to me, and I understand the risks and benefits of receiving the COVID-19 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 ☐ Moderna ☐ Novavax ☐ Janssen

Lot Number

Dosage: ☐ 0.3 ml ☐ 0.5 ml

Site: ☐ LD ☐ LT ☐ RD ☐ RT

Date Administered (M M / D D / Y Y Y Y)

Administered by:

Name _____ Title _____

Parent, Guardian

Name –

D.O.B –

Phone # –