Department of Corrections
WASHINGTON STATE

COVID-19 VACCINATION SCREENING AND CONSENT

Date of completion

SECTION A. EMPLOYEE/CONTRACT STAFF/VOLUNTEER

Last name		First name	Vaccine clinic location	Employee personnel number
Date of birth	Sex	Mother's maiden name	Emergency contact name	Emergency contact number

Recipient address (street, city, zip)

Vaccine dose requested (check one): ☐ 1st ☐ 2nd ☐ 3rd* ☐ Booster

*For those with moderate to severe immune compromise and should be discussed with primary care provider

Have you previously had a dose of COVID-19 vaccine? If yes, which one?

☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ No previous dose

SCREENING - ANSWER ALL QUESTIONS

Have you had a severe allergic reaction to the COVID-19 vaccine? ☐ Yes ☐ No

Have you had any other adverse reaction to the COVID-19 vaccine? ☐ Yes ☐ No

Have you ever had multisystem inflammatory syndrome from COVID-19 infection? ☐ Yes ☐ No

Have you ever had Guillain-Barre syndrome? ☐ Yes ☐ No

Have you ever had myocarditis or pericarditis? ☐ Yes ☐ No

Did you need to be seen by a provider for chest pain, shortness of breath, or palpitations or receive a new medical diagnosis? ☐ Yes ☐ No

Do you have a history of heparin-induced thrombocytopenia (HIT)? ☐ Yes ☐ No

Do you currently have a fever or respiratory illness? ☐ Yes ☐ No

Have you ever had a severe adverse reaction to any vaccine or injectable therapies or a component of the vaccine (e.g., polyethylene glycol, polysorbate)? ☐ Yes ☐ No

If you answer "Yes" to any of the above, you will NOT receive the vaccine at this time.

If you answer "Yes" to any of the questions below, please review the Emergency Use Authorization (EUA) fact sheet before receiving the vaccine.

Do you currently have a clotting/bleeding disorder or low platelet count? ☐ Yes ☐ No

Do you have a weakened immune system (e.g., cancer) or do you take immunosuppressive drugs or therapies? ☐ Yes ☐ No

I have reviewed the fact sheet and am aware of my risks and have been advised to speak with my provider with any concerns. I choose to receive the vaccine at this time. ☐ Yes ☐ No

OFFICE USE ONLY ☐ Check if eligible to receive vaccine. Immunizer's initials _____

VACCINE CONSENT

☐ I have read, or had explained to me, the EUA fact sheet for the COVID-19 vaccine. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the COVID-19 vaccine. I understand that as with all vaccines, there is no guarantee that I will become immune or that I will not experience side effects. I hereby give my consent to receive the COVID-19 vaccine. I have been instructed that as a result of the vaccination, I may experience some of the side effects described on the EUA fact sheet. I have made the decision to receive the vaccine freely and voluntarily. I understand I should remain in the vaccination area for at least 15 minutes, as determined by my medical history, after vaccination to be monitored. I understand this form will be maintained in my confidential medical file.

Signature	Date

SECTION B. ADMINISTERING EMPLOYEE/CONTRACT STAFF

☐ The employee received the current EUA fact sheet corresponding to the COVID-19 vaccine. If the vaccine requires multiple doses, the employee has been directed to schedule another appointment at the designated interval for this type of vaccine.

Name	Job title	Signature

Date vaccine given	Site of injection	EUA date	Dose or booster	Manufacturer	Lot number	Beyond Use date
	☐ L arm ☐ R arm					

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.

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