Department of Corrections
WASHINGTON STATE

PATIENT I.D. DATA:
(name, DOC #, birthdate)

COVID-19 VACCINATION

DATE	FACILITY	UNIT (optional)

Instructions: To be completed for each dose administered

Section 1: History	
☐ No ☐ Yes	**A.** Have you previously had a dose of COVID-19 vaccine? If yes, complete this section. 1) Check appropriate brand and write date of last dose. ☐ Janssen (Johnson & Johnson) ☐ Moderna ☐ Pfizer Date of last dose: _____ 2) Did you have a severe allergic reaction?..... ☐ No ☐ Yes* 3) Did you have any other adverse reaction? ..... ☐ No ☐ Yes* 4) Did you need to be seen by a provider for chest pain, shortness of breath, or palpitations or were you given a new medical diagnosis?..... ☐ No ☐ Yes*
☐ No ☐ Yes*	B. Have you ever had a severe adverse reaction to any vaccine or injectable therapies or a component of the vaccine, such as polyethylene glycol or polysorbate?
☐ No ☐ Yes**	C. Do you currently have a fever or respiratory illness?
☐ No ☐ Yes**	D. Have you ever had Guillain-Barré syndrome?
☐ No ☐ Yes**	E. Have you ever had myocarditis or pericarditis?
☐ No ☐ Yes**	F. Have you ever had multisystem inflammatory syndrome from COVID-19 infection?
☐ No ☐ Yes***	G. Do you have a history of heparin-induced thrombocytopenia (HIT)?
☐ No ☐ Yes***	H. Do you currently have a clotting disorder, bleeding disorder, or low platelet count?
☐ No ☐ Yes****	I. Do you have a weakened immune system caused by a condition such as cancer or do you take immunosuppressive drugs or therapies?

* **If patient answered "Yes" to any of these questions**, STOP and review the triage document and refer to practitioner for answers in triage document yellow column.

** **If patient answered "Yes" to any of these questions**, STOP and consult with on-site practitioner. Vaccinate or create a follow-up encounter based on practitioner recommendation.

*** **If patient answered "Yes" to this question**, assist in and verify bleeding control prior to end of appointment.

**** **If patient answered "Yes" to this question,** review the **Information Sheet for Immunocompromised Patients Considering COVID-19 Vaccination** with the patient in order to provide informed consent.

Distribution: **ORIGINAL** - Health Record **COPY** - Scanned to DOC HS COVID Vaccine

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Section 2: Education

☐ Patient read Emergency Use Authorization Fact sheet for recipients (EUA)

☐ Risks/benefits of recommended intervention explained; patient consents

_____ Employee giving vaccination initial that education was given EUA Version:

Section 3: CONSENT / REFUSAL

I have read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine.

☐ I am consenting and ask that the vaccine be given to me. I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING

☐ I am **refusing the vaccination that is recommended** and offered to me at this time. I understand the risks of this decision.

Patient Signature _____ Date _____

Guardian Printed Name and Signature _____ Date _____

Section 4: Vaccination

☐ 0.5 ml **Moderna Bivalent** vaccine given intramuscularly.

☐ 0.3 ml **Pfizer-BioNTech Bivalent** vaccine given intramuscularly.

☐ Other:

Lot number: **Expiration/Beyond Use date**:

Deltoid (circle one): L R **Dose Number** (circle one): 1 2 3 Booster

Date vaccine given:

Section 5. Observation

_____ **Employee giving vaccination initials: Patient was observed for 15 minutes after receiving vaccine dose.**

Print/stamp name of employee giving vaccination _____ Signature of employee giving vaccination _____ Job Title of employee giving vaccination

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

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