Department of Corrections
WASHINGTON STATE

PATIENT I.D. DATA /
DATOS DE IDENTIDAD DEL PACIENTE:
(name, DOC #, birthdate /
nombre, Núm. DOC, fecha de nacimiento)

COVID-19 VACCINATION / *VACUNA CONTRA COVID-19*

DATE / *FECHA*	FACILITY / *INSTALACION*	UNIT / *UNIDAD* (optional / *opcional*)

Instructions: To be completed for each dose administered

Section 1: History / *Historia clínica*	
☐ No ☐ Yes/*Sí* *	**A.** Severe adverse reactions to to any vaccine or injectable therapy other than soreness at the injection site or mild flu-like illness / *Reacciones adversas a cualquier vacuna o terapia inyectable que no sea el dolor en el lugar de la inyección o una enfermedad leve como la influenza*
☐ No ☐ Yes/*Sí* **	**B.** Current FEBRILE or respiratory illness / *Enfermedad FEBRIL o del sistema respiratorio en la actualidad*
☐ No ☐ Yes/*Sí* **	**C.** Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19 in the past 90 days? / *¿La persona a vacunar ha recibido una terapia de anticuerpos pasivos como tratamiento para COVID-19 en los últimos 90 días?*
☐ No ☐ Yes/*Sí* ***	**D.** Current clotting disorder, bleeding disorder, or low platelet count / *Trastorno actual de coagulación, sangrado o bajo número de plaquetas*
☐ No ☐ Yes/*Sí* ****	**E.** Do you have a weakened immune system caused by a condition such as or cancer or do you take immunosuppressive drugs or therapies? *¿Tiene el sistema inmunitario debilitado por una enfermedad como el cáncer o toma medicamentos o terapias inmunosupresoras?*

***** **If patient answered "Yes" to this question**, 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.

Section 2: Education /*Educación*

☐ Patient read Emergency Use Authorization Fact sheet for recipients (EUA) / *El paciente leyó la Hoja de datos de autorización de uso en emergencias para los receptores (EUA)* por sus siglas en ingles.

☐ Risks/benefits of recommended intervention explained; patient consents / *Explicación de los riesgos/beneficios de la intervención recomendada; consentimiento del paciente*

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

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

Department of Corrections
WASHINGTON STATE

PATIENT I.D. DATA /
DATOS DE IDENTIDAD DEL PACIENTE:
(name, DOC #, birthdate /
nombre, Núm. DOC, fecha de nacimiento)

COVID-19 VACCINATION / *VACUNA CONTRA COVID-19*

DATE / *FECHA*	FACILITY / *INSTALACION*	UNIT / *UNIDAD* (optional / *opcional*)

Section 3: CONSENT / *NEGATIVA DE DAR CONSENTIMIENTO*

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 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.

He leído, o me han explicado, la Autorización de Uso de Emergencia (EUA) para la vacuna COVID-19. He tenido la oportunidad de hacer preguntas que fueron respondidas a mi satisfacción. Creo que entiendo los beneficios y riesgos de la vacuna COVID-19 y pido que la vacuna se me aplique a mí o a la persona nombrada anteriormente para la que estoy autorizado a hacer esta solicitud (tutor). SE ME HA ACONSEJADO QUE ESPERE DE 15 A 30 MINUTOS DE OBSERVACIÓN DESPUÉS DE RECIBIR MI VACUNA ANTES DE SALIR.

_____ _____
Patient Signature / *Firma del paciente* Date / *Fecha*

_____ _____
Guardian Signature / *Firma del tutor* Date / *Fecha*

Section 4: Vaccination / *Vacuna*

☐ 0.5 ml **Moderna** vaccine given intramuscularly. ☐ 0.3 ml **Pfizer-BioNTech** vaccine given intramuscularly.

☐ 0.5 ml **Janssen** (Johnson & Johnson) vaccine given intramuscularly. (Single dose only required.)

Lot number: **Expiration date**:

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

Date vaccine given:

Section 5: Follow-up / *Seguimiento*

Second vaccination date: _____/_____/_____

Reschedule 1st vaccination date based on practitioner recommendation: _____/_____/_____

Reason for rescheduled vaccination:

Section 6. Observation / *Observación*

_____ **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

REFUSAL OF CONSENT / *NEGATIVA DE DAR CONSENTIMIENTO*

I am **refusing the vaccination that is recommended** and offered to me at this time. I understand the risks of this decision. / ***Me niego a aceptar la vacuna recomendada*** *que se me ofrece en este momento. Entiendo los riesgos de esta decisión.*

_____
PATIENT SIGNATURE/*FIRMA DEL PACIENTE*

_____ _____
WITNESS NAME (PRINT/STAMP)/*NOMBRE DEL TESTIGO* **WITNESS SIGNATURE/*FIRMA DEL TESTIGO***