United Tribes Technical College

Coronavirus Vaccine

Questionnaire and Consent Form

Patient Name _____

Date of Birth _____ Age _____ Temperature _____

	Yes	No	Don't know	
Have you ever tested positive for Covid-19 or has a doctor told you that you had Covid-19 in the past?				Date of diagnosis:
Were you treated with passive antibody therapy? (monoclonal antibodies or convalescent plasma)				
Have you ever received a dose of Covid-19 vaccine? ☐ Pfizer-BioNTech ☐ Janssen (Johnson & Johnson) ☐ Other ☐ Moderna ☐ Novavax How Many doses of COVID-19 vaccine were administered? _____				
Did you bring the vaccination record card or other documentation?				
Are you feeling sick or unwell in today?				
Do you have any allergies that you are aware of?				Allergies:
Have you ever had a severe allergic reaction such as anaphylaxis to anything? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing)*				
Have you ever had an allergic reaction to: ☐ a component of a COVID-19 vaccine, including either of the following: polyethylene glycol (PEG), which is found in some medications, such as laxatives and preps for colonoscopy procedures ☐ polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids ☐ a previous dose of COVID-19 vaccine ☐ a vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 component, but it is not known which component elicited the immediate reaction ☐ another vaccine (other than COVID-19 vaccine) or an injectable medication?				
Do you have a bleeding disorder or are you taking a blood thinner?				
Do you have a health condition or undergoing treatment that makes you moderately or severely immunocompromised? (*This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency)*				

Have you received the COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?				
Do you have any of the following? Check all that apply ☐ Have a history of myocarditis or pericarditis ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)? ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT) ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS) Have a history of Guillain-Barré Syndrome (GBS) ☐ Have a history of COVID-19 disease within the past 3 months? ☐ Have dermal fillers ☐ Pregnant or breastfeeding ☐ Have had a vaccine or injection of **ANY** kind in the past 14 days?				

CONSENT:

I have been provided a copy of the FACT SHEET FOR RECIPIENTS AND CAREGIVERS.
I have read and understand the information provided about the disease and the vaccine.
I understand that with any vaccine there are possible risks involved. I believe the benefits of vaccine outweigh any possible risks or adverse events.
I have had the opportunity to have all my questions about this vaccine answered.
I consent to receive the Covid-19 Vaccine.

_____ _____

Patient or Guardian Signature Date

_____ _____

Reviewed by Date