



# Colorado COVID-19 Vaccine Screening and Administration Form



Please print neatly in capital letters as shown in the example: E X A M P L E    1 2 3 Please answer all questions as completely as possible. Please use only **black** ink to complete form. The administration record is on the reverse side of this document.

Please complete ALL the information below as accurately as possible. If you are completing this form for your minor child, do not use nick-names or abbreviations, except where allowed. All information will be kept confidential.

Patient/Child Last Name	Patient/Child First Name	M.I.

Date of Birth M M / D D / Y Y Y Y	Age (years)	Age (months)	Patient/Representative Daytime Phone Number

If under 18 years of age please complete Parent First Name	Parent Last Name

Address	Apt. Number

City	County	State

Zip Code	E-mail Address

Gender Identity  F  M  Transgender Female/Feminine  Transgender Male/Masculine  Non-Binary  Un-specified  Decline to Provide

Are you Hispanic/Latin/a/o/x? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Provide	Race(s) check all that apply <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black, African American <input type="checkbox"/> Other <input type="checkbox"/> Decline to Provide <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White
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Health Insurance (OPTIONAL-INSURANCE NOT REQUIRED FOR VACCINATION) Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Kaiser Permanente <input type="checkbox"/> United Healthcare <input type="checkbox"/> Other Private <input type="checkbox"/> No Insurance <input type="checkbox"/>	Insurance Policy Number

If you have already received your Primary Dose(s) of a COVID-19 vaccine, please tell us which vaccine(s) you received and the date(s) of vaccination.  
 Dose(s) received: Dose 1: Vaccine Brand \_\_\_\_\_ Vaccination Date \_\_\_\_/\_\_\_\_/\_\_\_\_ | Dose 2: Vaccine Brand \_\_\_\_\_ Vaccination Date \_\_\_\_/\_\_\_\_/\_\_\_\_

If you have already received more than two (2) doses of a COVID-19 vaccine, please tell us which additional dose(s) you received, the vaccine(s), and the date(s) of vaccination.  
 Additional Dose received for High Risk Conditions : Vaccine Brand \_\_\_\_\_ Vaccination Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Booster Dose: Vaccine Brand \_\_\_\_\_ Vaccination Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Additional Booster Dose: Vaccine Brand \_\_\_\_\_ Vaccination Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Health Screening Questions	Yes	No	Don't Know
1. Are you or your child sick today or have a fever?			
2. Have you or your child had an allergic reaction to polysorbate, polyethylene glycol, or a previous dose of COVID-19 vaccine?			
3. Have you or your child ever had a serious allergic reaction (anaphylaxis) to another vaccine or any injectable medication?			
4. Have you or your child had severe allergic reaction (anaphylaxis) to foods, pets, venom, environmental or oral medications?			
5. Do you or your child have a bleeding disorder, are on long-term aspirin therapy, or take other blood thinners?			
6. Have you or your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) after receiving a vaccine?			
7. Have you received any dermal fillers (Juvaderm®, Restylane®, etc.)? (only applies to mRNA vaccines)			
8. Do you have a history of blood clots or have risk factors for developing blood clots? (Janssen vaccine only, applies to females ages 18-49)			
9. Do you or your child have a history of myocarditis or pericarditis? (Especially males ages 12-29 years after receiving a dose of mRNA vaccine)			
10. Do you or your child have a history of heparin-induced thrombocytopenia (HIT)?			
11. Do you or your child have a history of Multisystem Inflammatory Syndrome known as MIS-C (in children) or MIS-A (in adults) after a COVID-19 infection?			
12. Are you or your child immunocompromised? (See additional dose section on next page)			

