STATE OF ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Immunization COVID-Flu Form

Privacy Practice Notification Received? ☐ Yes ☐ No

Date: __________ Emergency Use Authorization or VIS Fact Sheet received? ☐ Yes ☐ No

PARTICIPANT'S INFORMATION

First Name ____________ Middle Initial ____________ Last Name ____________

Gender ☐ Male ☐ Female ☐ Other

Date of Birth ____________ Age ____________

Mailing Address: Street, City, State, Zip ____________

Cell Phone ____________ Home Phone ____________

Race
Check all that apply ☐ American Indian/Alaska Native ☐ Asian ☐ White ☐ Other ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Decline

Hispanic? ☐ Yes ☐ No ☐ Decline

Insurance Type ☐ Medicaid ☐ Medicare ☐ Tricare/VA ☐ Other **P**rivate Insurance ☐ Uninsured

GUARDIAN OR AUTHORIZED PERSON INFORMATION

Guardian First and Last Name ____________

Cell phone or home phone number ____________

I am currently ☐ Employed ☐ Unemployed ☐ Self-Employed ☐ Retired

	Vaccine Screening Questions	Yes	No	Don't Know
1.	**Are you feeling sick today?**	☐	☐	☐
2.	**Do you have a History of Guillain-Barré Syndrome (GBS)?**	☐	☐	☐
3.	**Do you have any allergies, such as to medications, food, or vaccine components? If yes, to what?** ____________	☐	☐	☐
4.	**Have you ever had a serious reaction to a vaccine or any injectable? If yes, to what?** ____________	☐	☐	☐
COVID Vaccine Only:				
5.	**Have you ever received a dose of a COVID-19 vaccine? If Yes, which vaccine product?** ____________	☐	☐	☐
6.	**Check all that apply to you:**			

☐ Female between ages 19 and 49.
☐ Male between ages 12 and 29.
☐ History of myocarditis or pericarditis.
☐ History of treatment with monoclonal antibodies or convalescent serum.
☐ Diagnosed with Multisystem Inflammatry Syndrome (MIS-C or MIS-A) after a COVID-19 infection.
☐ Have a weakened immune system (i.e. HIV infection, cancer) or take immunosuppressive drugs.
☐ Have a bleeding disorder
☐ Take a blood thinner
☐ History of heparin-induced thrombocytopenia (HIT)
☐ Currently pregnant or breastfeeding
☐ Have received dermal fillers

Please read and sign the top of the next page.

Informed Consent - Please read and sign if you agree.

My signature below indicates that:

- **I have voluntarily chosen to receive the vaccination and consent to the administration.**
- **I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient or am authorized to consent on behalf of the client.**
- **I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") provided for the vaccine(s) to be administered.**
- **I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.**
- **I understand the benefits and risks of the vaccine(s).**
- **I will immediately alert the provider of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine.**
- **I understand I should remain in the area for 15 minutes after the vaccination for observation or 30 minutes if I have any history of severe allergic reaction or anaphylaxis.**

____

Participant/Guardian/Authorized Representative Signature Date

OFFICE USE ONLY

Vaccine (CVX)	**VFC/AVAP**	**Admin Site**	**Lot #**	**Manufacturer**	**EUA/VIS Date**
☐ **Pfizer-BioNTech COVID-19 vaccine 0.3mL**(208)	V07			**PFR**	
☐ **Moderna COVID-19 vaccine 0.5 mL** (207)	V07			**MOD**	
☐ **Moderna COVID-19 Booster - 0.25 mL** (207)	V07			**MOD**	
☐ **Janssen COVID-19 - 0.5 mL** (212)	V07			**JSN**	
☐ **Pfizer-BioNTech COVID PED – 0.2 mL** (218)	V07			**PFR**	
☐					
☐					
☐					

Additional Purpose of Visit

☐ Refer to ______________________ for ______________________

☐ ____

Notes

☐ Adverse Event ______________________________ ☐ VAERS Report completed________________

☐ ____

Provider name (print) ____

Provider name (signature) ____

Event Location ____________________

Name____________________________ **Arrival Time** __________

Birth Date________________________ **Exit Time** __________

Organization ______________________

Date______________________________

Administration Sites	
Left Thigh IM	LTI
Right Thigh IM	RTI
Left Deltoid IM	LDI
Right Deltoid IM	RDI
Intranasal	IN