My Turn

English

Age confirmation

☐ I certify that I, the person providing patient information, am at least 18 years of age.

Medical screening questions

	Yes	No
1. Are you feeling sick today?	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐
3. Has it been two or more months since your primary series or last booster?	☐	☐
4. Have you ever had an allergic reaction to (1) component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures, (2) Polysorbate, (3) a previous dose of COVID-19 vaccine (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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐
5. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐
6. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of the COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	☐	☐
7. Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?	☐	☐
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐
11. Do you have a history of heparin-induced thrombocytopenia (HIT)?	☐	☐
12. Are you pregnant or breastfeeding?	☐	☐
13. Have you received dermal fillers?	☐	☐
14. Do you have a history of myocarditis or pericarditis?	☐	☐
15. Has the patient ever had Guillain-Barré Syndrome (GBS)?	☐	☐
16. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	☐	☐
17. Does the patient have a history of thrombosis with thrombocytopenia (TTS) following an adenovirus-vectored vaccine (e.g., Johnson & Johnson, AstraZeneca or Sputnik COVID-19 vaccines)?	☐	☐
18. Have you received Jynneos or other orthopoxvirus/smallpox vaccine in the past 4 weeks?	☐	☐

Vaccination disclosures & consent

Life threatening allergic reactions to vaccines are very rare. Signs of a serious allergic reaction include: shortness of breath, hoarseness of wheezing, hives, paleness, weakness, elevated heart rate, or severe dizziness. These symptoms may occur within a few minutes, or up to 48 hours after the vaccination. If you are experiencing any of these symptoms, you should contact a healthcare provider immediately.

☐ Verbal consent: The patient or legal guardian has been provided the benefits and potential adverse reactions, and provides consent to receive the vaccine.

☐ I understand that all immunizations will be reported to the California Immunization Registry (CAIR2).

☐ I understand the information in the patient's CAIR2 record will be shared with the local health department and California Department of Public Health, shall be treated as confidential medical information, and shall be used only as allowed by law. I may refuse to allow the information to be further shared and can request the CAIR2 record be locked by visiting the request to lock my CAIR record web form: https://cairforms.cairweb.org/SharingRequestForm/SharingRequestForm?SharingType=1&Language=En

Name: _____ Date: _____

Date of Birth: _____ Gender: _____

Mother's First Name: _____ **(Required)**

Are you of Hispanic, Latino or Spanish Origin? (Please specify) _____

Race/Nationality: _____

Email: _____

Phone #: _____**(Required)**

Address: _____**(Required)**

Health Insurance Carrier (or "none): _____

Insurance ID #_____Medicare ID #_____

Signature: _____

----------Office UseOnly----------

Left ☐ Right ☐ Moderna ☐ lot#_____ Pfizer ☐ lot# _____