VALLEY HEALTH TEAM
LIVE BETTER. VIVE MEJOR.

COVID-19 VACCINE DEMOGRAPHIC AND CONSENT FORM

Pfizer, Moderna, and Janssen (Johnson and Johnson) COVID-19 Vaccines

SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)

Last Name	First Name	Middle Name

Date of Birth			Age in Years:	Sex (Gender assigned at birth)
Month	Day	Year		☐ Male ☐ Female

Race				Ethnicity
☐American Indian or Alaska Native	☐Native Hawaiian or Other	☐Other Asian	☐Other	☐Hispanic or Latino
☐Asian	☐Pacific Islander	☐Other Nonwhite		☐Not Hispanic or Latino
☐Black or African American	☐White	☐Other Pacific Islander		☐Unknown

Address		
City	State	Zip Code
Cell Phone Number		

Primary Insurance Carrier ID #:		Grp #:	
Insurance Company:		Insurance Company Phone #	
Insured Name:	Relationship:		Insured Date of Birth:

Secondary Insurance Carrier ID#:		Grp #:	
Insurance Company:		Insurance Company Phone #	
Insured Name:	Relationship:		Insured Date of Birth:

Is this the patient's first or second dose of the COVID-19 vaccination? ☐ First Dose ☐ Second Dose

- I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient and confirm that the patient is at least 16 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to Valley Health Team, Inc., and the California Department of Health (DOH) or its agents to administer the COVID-19 vaccine.
- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 or 30 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.

- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Valley Health Team, Inc. and It's associated Clinics, and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
- I acknowledge that: (a) I understand the purposes/benefits of California immunization registry and (b) DOH will include my personal immunization information in California SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize Valley Health Team, Inc. or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to Valley Health Team, Inc. or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if Valley Health Team, Inc. invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the Notice of Privacy Rights.

Signature of Patient or Authorized Representative: _____ **Date:** _____

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

TO BE COMPLETED BY VHT STAFF

Site (LD/RD)	Route	Manufacturer (MVX)	Lot #Unit of Use/ Unit of Sale	Expiration Date	Date of EUA Fact Sheet
	IM				

Administered at Location (Facility Name/ID):	
Administered at Location (Type):	
Administration Address:	
CVX (Product):	
Sending Organization:	

Vaccinator (Print Name):		Signature:		Date:	
Vaccine Administering Provider Suffix:					

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Dear Valley Health Team Patient:

In order to continue offering a variety of services to you and your family and comply with the terms of our grant funding, we are required to collect the following information on every patient that visits our facility. Your personal information is **not reported**, only de-identified answers, combined with all of our patients' responses are reported.

Please take a few minutes to complete the following information. If you have any questions or would like a representative to assist you with this, please let us know. We are happy to help!

1. Please select what best describes your living situation:

   ☐ Doubling up
   ☐ Not Homeless
   ☐ Shelter
   ☐ Street
   ☐ Transitional
   ☐ Unknown/Refused to report

2. Have you or any family member performed agriculturally related work in the last 3 years?

   ☐ Yes
   ☐ No

   If yes, which one best describes the type of work:

   ☐ Migrant farm work; you travel from home from town to town to where work is available (you do not establish a residence at the new work location)
   ☐ Seasonal farm work; you remain in your place of residence and work seasonal

3. Please select one of the following from the race listing:

   ☐ Asian
   ☐ Native Hawaiian/Pacific Islander
   ☐ White (Hispanic or Latino)
   ☐ American Indian or Alaska Native
   ☐ Native American Indian
   ☐ East Indian/Asian
   ☐ White (not Hispanic or Latino)
   ☐ Black/African American
   ☐ Unknown/Refused to report
   Other: _____

4. What is the primary language spoken in your household?

   ☐ Spanish
   ☐ English
   ☐ Refused to report
   ☐ Hindi
   ☐ Punjabi
   ☐ Other: _____

5. Do you need an interpreter?

   ☐ Yes
   ☐ No

6. Please select from the following ethnicity listing:

   ☐ Hispanic or Latino
   ☐ Not Hispanic
   ☐ Unknown/Refused to Report

7. Are you unable to work because of a physical or mental disability?

   ☐ Yes
   ☐ No

8. Have you completed service in the Uniformed Services of the United States?

   ☐ Yes
   ☐ No

9. What is your family's total annual income? _____

10. How many family members are there living in your household? _____

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Estimado Paciente de Valley Health Team:

Para continuar ofreciendo una variedad de servicios para usted y su familia y cumplir con los términos de nuestras becas de fondos estamos obligados a obtener la siguiente información sobre cada paciente que visita nuestros centros. Su información personal **no es** reportada, solo se informan las respuestas des identificadas combinadas con las respuestas de todos nuestros pacientes.

Por favor tome unos minutos para completar la siguiente información. Si tiene preguntas o desea que un represéntate lo ayude con esto, háganos saber. Estamos encantados de ayudarle!

1. Por favor seleccione la respuesta que mejor describe su situación de vivienda:

   ☐ En conjunto con alguien mas
   ☐ En hogar
   ☐ Hogar de refugio
   ☐ En la calle
   ☐ En Transición
   ☐ Desconocido/Negó a informar

2. ¿Usted o algún miembro de su familia han hecho trabajos relacionados con la agricultura en los últimos 3 años?

   ☐ Si
   ☐ No

   En caso que escogió SI, cual describe mejor el tipo de trabajo:

   ☐ Trabajo agrícola migratoria; Viaja de pueblo en pueblo hasta que hay trabajo disponible. (No establece una residencia en el nuevo lugar de trabajo).
   ☐ Trabajo agrícola de temporada; Permanece en su lugar de residencia y trabaja pro temporada.

3. Por favor seleccione su raza:

   ☐ Asiático
   ☐ Nativo de Hawaiano/Islas de Pacifico
   ☐ Blanco (Hispano o Latino)
   ☐ Indio Americano o Nativo de Alaska
   ☐ Indio Americano Nativo
   ☐ Otro: _____
   ☐ Indio del este/Asiático
   ☐ Blanco (No Hispano o Latino)
   ☐ Mas de una raza
   ☐ Negro/Afroamericano
   ☐ Desconocido/Negó a informar

4. ¿Cuál es el idioma principal que se habla en su hogar?

   ☐ Español
   ☐ Ingles
   ☐ Negó a informar
   ☐ Hindi
   ☐ Punjabi
   ☐ Otro: _____

5. ¿Necesita intérprete?

   ☐ Si
   ☐ No

6. Por favor seleccione de la lista de origen étnico:

   ☐ Hispano o Latino
   ☐ No Hispano
   ☐ Desconocido/Negó a informar

7. ¿No puede trabajar debido a una discapacidad física o mental?

   ☐ Si
   ☐ No

8. ¿Ha completado el servicio en los Servicios Uniformados de los Estados Unidos?

   ☐ Si
   ☐ No

9. ¿Cuál es el ingreso anual total de su familia? _____

10. ¿Cuántos miembros de la familia viven en su hogar? _____

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name _____

Age _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Another product _____			
3. Have you ever had an allergic reaction to: (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.)			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
• Polysorbate			
• A previous dose of COVID-19 vaccine			
4. 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.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
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. Are you pregnant or breastfeeding?			

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists

Lista de verificación antes de la vacunación contra el COVID-19

Para quienes reciban la vacuna:

Las siguientes preguntas nos ayudarán a determinar si hay alguna razón por la cual usted no debería ponerse la vacuna contra el COVID-19 hoy.
Si responde "sí" a alguna pregunta, eso no significa necesariamente que no debería vacunarse. Solo quiere decir que podrían hacerle preguntas adicionales. Si no entiende alguna pregunta, pídale a su proveedor de atención médica que se la explique.

Nombre del paciente _____

Edad _____

	Sí	No	No sé
1. ¿Se siente enfermo hoy?			
2. ¿Ha recibido alguna vez una dosis de la vacuna contra el COVID-19?			
• Si la respuesta es "sí", ¿cuál vacuna le pusieron? ☐ Pfizer ☐ Moderna ☐ Otro producto _____			
3. ¿Ha tenido alguna vez una reacción alérgica a lo siguiente? (Esto incluye una reacción alérgica grave [p. ej., anafilaxis] que haya requerido tratamiento con epinefrina o EpiPen®, o que haya hecho que tuviera que ir al hospital. También incluye una reacción alérgica que haya ocurrido dentro de 4 horas y que haya causado ronchas, inflamación o dificultad para respirar, incluso sibilancias).			
• Un componente de la vacuna contra el COVID-19, como el polietilenglicol (PEG), que se encuentra en algunos medicamentos como los laxantes y preparaciones para los procedimientos de colonoscopia			
• Polisorbato			
• Una dosis previa de la vacuna contra el COVID-19			
4. ¿Ha tenido alguna vez una reacción alérgica a otra vacuna (que no sea la vacuna contra el COVID-19) o a un medicamento inyectable? (Esto incluye una reacción alérgica grave [p. ej., anafilaxis] que haya requerido tratamiento con epinefrina o EpiPen®, o que haya hecho que tuviera que ir al hospital. También incluye una reacción alérgica que haya ocurrido dentro de 4 horas y que haya causado ronchas, inflamación o dificultad para respirar, incluso sibilancias).			
5. ¿Ha tenido alguna vez una reacción alérgica grave (p. ej., anafilaxis) a otra cosa que no sea un componente de la vacuna contra el COVID-19, al polisorbato, o a alguna vacuna o medicamento inyectable? Esto incluye alergias a alimentos, mascotas, medioambiente o medicamentos que se toman por la boca.			
6. ¿Ha recibido alguna vacuna en los últimos 14 días?			
7. ¿Ha tenido alguna vez un resultado positivo en la prueba del COVID-19 o un médico le ha dicho que usted tuvo COVID-19?			
8. ¿Ha recibido terapia pasiva con anticuerpos (anticuerpos monoclonales o suero de convaleciente) como tratamiento para el COVID-19?			
9. ¿Tiene el sistema inmunitario debilitado debido a algo como infección por el VIH o cáncer, o usa medicamentos o terapias inmunodepresores?			
10. ¿Tiene un trastorno hemorrágico o toma un anticoagulante (*blood thinner*)?			
11. ¿Está embarazada o amamantando?			

Formulario revisado por _____ **Fecha** _____