Department of Corrections
WASHINGTON STATE

CORONAVIRUS (COVID-19) VACCINATION SCREENING AND CONSENT

Date of completion

SECTION A. EMPLOYEE / CONTRACT STAFF / VOLUNTEER

Last name		First name	Vaccine clinic location	Employee personnel number
Date of birth	Sex	Mother's maiden name	Emergency contact name	Emergency contact number

Recipient address (street, city, zip)

Vaccine dose (check one): ☐ 1st ☐ 2nd

If this is your second dose, what vaccine was your first?

☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Don't know

SCREENING - ANSWER ALL QUESTIONS

Are you currently sick (e.g., cold, fever, new illness)? ☐ Yes ☐ No

Have you ever had a severe allergic reaction (e.g. anaphylaxis to any vaccination, including the COVID-19 vaccine or another injectable medication? ☐ Yes ☐ No

Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 within the last 90-days? ☐ Yes ☐ No

If you answer "Yes" to any of the above, you will NOT receive the vaccine at this time.

If you answer "Yes" to any of the questions below, please review the fact sheet prior to receiving the vaccine.

Are you pregnant, planning to become pregnant within the next two months, or breast feeding? ☐ Yes ☐ No

If you're unsure, you should speak with your primary care provider.

Are you receiving anticoagulant therapy that would cause problems with bleeding from an injection site? ☐ Yes ☐ No

Have you taken medications that would weaken your immune system in the past three months, such as cortisone, prednisone, anticancer drugs or radiation therapy? ☐ Yes ☐ No

Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease or any other immune system problem? ☐ Yes ☐ No

I have reviewed the fact sheet and am aware of my risks and have been advised to speak with my provider with any concerns. I choose to receive the vaccine at this time. ☐ Yes ☐ No

OFFICE USE ONLY ☐ Check if eligible to receive vaccine. Immunizer's initials _____

VACCINE CONSENT

☐ **I give my consent for vaccination.** I have been provided with the Emergency Use Authorization fact sheet or other informational pamphlet corresponding to the COVID-19 vaccine that I am receiving. I have read, or had read to me, the information provided about the COVID-19 vaccine and this Consent Form. I have had the chance to ask questions that were answered to my satisfaction. I understand the nature, alternatives, benefits and risks of vaccination. I understand that as with all vaccines, there is no guarantee that I will become immune or that I will not experience side effects. I hereby give my consent to receive the COVID-19 series. I have been instructed that as a result of the vaccination, I may experience some of the side effects described on the EUA fact sheet or other informational pamphlet. I have made the decision to receive the vaccine freely and voluntarily. I understand I should remain in vaccination area for 15 minutes after vaccination to be monitored. I understand this form will be maintained in my confidential medical file.

Signature	Date

SECTION B. ADMINISTERING STAFF

☐ The employee received the current Emergency Use Authorization sheet or other informational pamphlet corresponding to the COVID-19 vaccine. This vaccine requires multiple doses and the employee has been directed to schedule another appointment at the designated interval for this type of vaccine.

Name	Job title	Signature

Date	Site of injection	EUA date	Dose	Manufacturer	Lot number	Expiration date
	☐ L Arm ☐ R Arm					

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