Maine CDC HEALTH SCREEN & PERMISSION FORM – COVID-19 Vaccine

Please answer the following questions about the person to be vaccinated.

Name:	Date of Birth:	Age:	Preferred Language:
Do you have health insurance? ☐Yes ☐ No If yes: ☐ Public ☐ Private	Gender: ☐ Male ☐ Female ☐Non-Binary/X ☐Transgender ☐Prefer not to disclose ☐Other _____		

Race:		Ethnicity:
☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific Islander	☐Black or African American ☐White ☐Other Race	☐Hispanic/Latino ☐Non-Hispanic/Non-Latino

Do you have a disability that has resulted in eligibility for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)? ☐Yes ☐No ☐Prefer not to disclose

Street Address:	City/Zip:	Phone:	Email:

Please answer the following questions about the person named above:	**Yes**	**No**
Have you ever received a dose of COVID-19 vaccine? (*If yes, documentation is required)*	☐	☐
Have you had, in the last 10 days, fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?	☐	☐
Have you been advised to isolate or quarantine for COVID-19 at this time?	☐	☐
1. Have you ever had a severe allergic reaction (e.g., anaphylaxis)? For example, a reaction for which you were treated with epinephrine or EpiPen, or had to go to the hospital.	☐	☐
2. Have you ever had a non-severe allergic reaction to a previous COVID-19 vaccine? For example, did you have hives, swelling, or wheezing within 4 hours of vaccination?	☐	☐
3. Have you ever had an allergic reaction to polyethylene glycol (PEG, found in found in some medications such as laxatives and preparations for colonoscopy procedures) or polysorbate? (found in some vaccines, pills, & IV steroids)	☐	☐
4. Have you received any other vaccines in the last 14 days?	☐	☐
5. Have you received passive antibody therapy for COVID-19 within the past 90 days?	☐	☐
6. Do you have a weakened immune system for which you take immunosuppressive medications?	☐	☐
7. Do you have a bleeding disorder or are you taking a blood thinner (e.g. Coumadin, Xarelto)	☐	☐
8. Are you pregnant or breastfeeding?	☐	☐
9. Do you have any dermal fillers?	☐	☐

If you answered "Yes" to any of the above questions, please speak with the Clinical Lead at this site before proceeding

PERMISSION TO VACCINATE

- I was given a copy of the Emergency Use Authorization Fact Sheet, which I have read or had this fact sheet explained to me, and I understand the benefits and risks of the COVID-19 vaccine.
- I understand that a record of this vaccination will be entered into the Maine Immunization Information System, ImmPact.
- I understand that I am advised to stay on site today for at least 15 minutes post-vaccination.
- **I give permission for the COVID-19 vaccine to be given to the person named above by signing below.**

X_____Date:_____

Signature of adult to be vaccinated, OR Signature of guardian of person to be vaccinated

X_____Date:_____

Signature of interpreter (if applicable)

FOR OFFICE USE ONLY:

Dose	**Date Dose Administered**	**Vaccine Manufacturer**	**Lot Number**	**Dose Volume**	**Signature and Credentials of Vaccine Provider**	**Injection Site - Deltoid**	**Route**	**EUA date**
Dose 1	/ /					Left Right	☐IM	
	Immediate Reaction					Vaccine Expiration		
	COVID-19 Vaccination Card Completed: ☐ Y ☐ N							