DATA COLLECTION FORM FOR COVID-19 VACCINE ADMINISTRATION
Oklahoma City Area Office COVID-19 Community Event
701 Market Drive, Oklahoma City, OK 73114
Event Date: March 29, 2021

Section 1: Patient or Patient Representative to complete this section – Please PRINT

Last Name (legal):	**First Name (legal):**	**Date of Birth:**

Primary Language:
☐ English
☐ Other:

Birth Sex:
☐ Female
☐ Male
☐ Decline

Marital Status:
☐ Single ☐ Separated
☐ Married ☐ Widow/Widower
☐ Other:

Ethnicity:
☐ Not Hispanic or Latino
☐ Hispanic or Latino Decline to Answer
☐ Other:

Race:
☐ American Indian or Alaska Native
☐ White
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ Asian
☐ Declined to answer
☐ Other:

Tribal Membership:
☐ None/Household Member

Street Address or PO Box:

City:

Phone Number:	**State:**	**Zip Code:**

I certify that the information provided above is true to the best of my knowledge.

_____
Signature of Patient/Parent/Legal Guardian/Representative

Identity verified with:
☐ CDIB
☐ State/Federal ID

COVID-19 Vaccine Screening Questionnaire reviewed and vaccination administration deemed appropriate:
☑ Yes ☐ No ☐ Precaution identified and vaccination in an alternate setting needed

Manufacturer:	**Lot Number:**	**Expiration Date:**	**Injection Volume:**
Janssen	1805029	05/25/2021	0.5ml

Immunization Site/Route:
☐ Left Deltoid IM ☐ Right Deltoid IM

Administration Time:

Observation Time:
☐ 15 minutes ☐ 30 minutes

Name of Vaccinator:

Administration Notes:

Education provided to patient:
☑ Vaccine literature provided Duration: 1 minutes
☑ Information given on benefits, side effects, post immunization care Duration: 1 minutes
Level of Understanding: ☑ Good ☐ Fair ☐ Poor **Readiness to Learn:** ☑ Receptive

Assessment after injection: Patient sent to observation area for recommended monitoring per CDC.

☐ Vaccination documentation completed in EHR

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 ☐ Janssen (Johnson & Johnson) ☐ 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 a COVID-19 vaccine including either of the following:			
○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.	☐	☐	☐
• A previous dose of COVID-19 vaccine.	☐	☐	☐
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.	☐	☐	☐
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, or any vaccine or injectable medication? This would include food, pet, venom, 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?	☐	☐	☑
12. Do you have dermal fillers?			

Screener Name/ Form reviewed by: _____

Date 03/29/2021

03/05/2021 CS321629-E

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

Acknowledgement of Receipt of IHS Notice of Privacy Practices

I hereby acknowledge receipt of the Indian Health Service (IHS) Notice of Privacy Practices at the following Oklahoma City Area Indian Health Facility: Oklahoma City Area Office for Clinton Indian Health Center

_____

Name of Patient (Please Print)

_____ 03/29/2021

Signature of Patient Date

****

If patient is unable to sign:

_____ _____

Name of Legal Representative Relationship to Patient

_____ _____

Signature of Patient Representative Date

_____ _____

Signature and Title of OCA Staff Date

Staff Only: For Patients Unable to Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of the IHS Notice of Practices because:

_____

_____ _____

Signature of IHS OCA Staff Date

IHS Staff Use Only: Health Record Number: _____ D.O.B. _____