Nash County

NASH COUNTY HEALTH DEPARTMENT

COVID-19 Recipient Vaccination Questionnaire

☐ Pfizer BioNTech

☐ Moderna

PERSONAL INFORMATION AND CONTACT INFORMATION ***(Please fill out ALL the information below)***

First Name: _____ **Last Name:** _____

Date of Birth: _____ / _____ / _____ **Email:** _____

☐ I do not have an email / I do not wish to disclose this information

Street: _____

City: _____ **County:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Mobile Phone:** _____

Communication Preference: ☐Email ☐SMS ☐Both ☐None

Race:
- ☐Asian
- ☐Black or African American
- ☐White
- ☐Other
- ☐American Indian or Alaska Native Tribe:

Ethnicity:
- ☐Hispanic or Latino
- ☐Not Hispanic or Latino

Gender:
- ☐Male
- ☐Female
- ☐Unknown

RISK LEVEL INFORMATION

Vaccine Availability:
- ☐ Frontline essential workers
- ☐ Anyone 75 years or older
- ☐ Anyone 65-74 years old
- ☐ Anyone 16-64 years old with high-risk medical conditions

Are you planning to be responsible for administration of the Vaccine? ☐Yes ☐No

Are you an Essential Frontline Worker (Police, Food Processing, Teachers, etc.)? ☐Yes ☐No

Employer / Retired: _____ Duty(ies): _____

MEDICAL INFORMATION

Review the below list of conditions known to increase risk of severe illness to COVID-19:

- ☐Asthma
- ☐Cancer
- ☐Cerebrovascular Disease
- ☐Chronic Obstructive Pulmonary Disease
- ☐Chronic Kidney Disease
- ☐Cystic Fibrosis
- ☐Hypertension or High Blood Pressure
- ☐Type 1 Diabetes Mellitus
- ☐Type 2 Diabetes
- ☐Immunocompromised from solid organ transplant
- ☐Immunocompromised state (weakened immune system)
- ☐Liver Disease
- ☐Neurologic conditions, such as Dementia
- ☐Obesity
- ☐Overweight (BMI > 25 kg/m2, but < 30 kg/m2)
- ☐Pregnancy
- ☐Pulmonary Fibrosis (having damaged or scarred lung tissues)
- ☐Sickle Cell Disease
- ☐Smoker
- ☐Thalassemia (a type of blood disorder)
- ☐None

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Questions 1-3 require consultation with a medical provider if the answer if Yes or Don't Know	**YES**	**NO**	**Don't Know**
1. Are you feeling sick today?			
2. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?			
3. Have you ever received a dose of COVID-19 vaccine? If so, which vaccine did you receive: ☐Pfizer ☐Moderna ☐Another vaccine product (Name of Vaccine Product: _____)			
Questions 4 requires consultation with a medical provider if the answer is Yes.	**YES**	**NO**	**N/A**
4. If you have received a trial vaccine as a part of a COVID-19 vaccine trail, has your trial sponsor determined it is feasible to receive additional doses? ▪ If yes, o Name of vaccine received _____ o Number of doses received _____			
Questions 5-9 require additional nursing interventions as defined in the Standing Order.	**YES**	**NO**	
5. Do you have a bleeding disorder or are you taking a blood thinner?			
6. Have you received passive antibody therapy as treatment for COVID-19? Date patient received passive antibody therapy: _____			
7. Are you Immunocompromised (e.g. has cancer, has leukemia, has HIV/AIDS, other immune system problems or taking medication that affects your immune systems, etc.)?			
8. Are you pregnant or planning to become pregnant?			
9. Are you breastfeeding?			

Form Reviewed by: _____ _____ **Date:** _____

CONSENT

☐ I certify that I am: (a) at least 16 years of age (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an "applicable Provider"), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine. I understand that the health data shared within this questionnaire will be used to determine my eligibility for receiving the COVID-19 vaccination and further determine timing of when the vaccine will be made available to me.

Signature of Recipient: _____ _____

(Do not write below this line)

Date Vaccinated: _____ **Vaccination Site:** ☐ **LD** ☐ **RD** ☐ **LL** ☐ **RL**

Lot #_____ **Manufacturer:** _____ ____ **NDC#** _____

Exp. Date: _____ **Given By:** _____ _____

NCHD 01/2021