2021 VHA SAVE LIVES ACT COVID-19 VACCINATION WORKSHEET

Name _____

Social Security # _____

Date of Birth _____

Address _____

City _____ **Zip Code** _____

Phone _____

Email _____

Birth Sex: Male Female

Gender: _____

Eligibility

- ☐ Non-Enrolled Veteran
- ☐ Spouse/Caregiver
- ☐ Other: _____

Veteran Data

Branch of Service: _____
Date of Separation: _____
Total Time Active Duty: _____
Character of Discharge: _____

Spouse / Caregiver Data

Social Security # of Veteran: _____

Race:

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Hawaiian/Pacific Islander
- ☐ Black/African American
- ☐ White
- ☐ Other
- ☐ Decline to Answer

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino

Medical Conditions:

- ☐ None
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Condition
- ☐ Liver Condition
- ☐ Kidney Condition
- ☐ Immunocompromised
- ☐ Pregnant
- ☐ Obesity
- ☐ Other _____

Pre-Vaccination Checklist

☐ NO ☐ YES 1. Are you feeling sick today?

☐ NO ☐ YES 2. Have you ever received a dose of COVID-19 vaccine?
- If no, will you be available to receive your 2nd dose
- If Yes, which vaccine product did you receive?
  ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Other _____

☐ NO ☐ YES 3. Have you ever had a severe allergic reaction (i.e., 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? To what?
- Was the severe allergic reaction after receiving a COVID-19 vaccine? ☐ NO ☐ YES

☐ NO ☐ YES 4. Have you received any vaccine in the last 14 days?

☐ NO ☐ YES 5. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?

☐ NO ☐ YES 6. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?

☐ NO ☐ YES 7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?

☐ NO ☐ YES 8. Do you have a bleeding disorder or are you taking a blood thinner?

☐ NO ☐ YES 9. Are you pregnant or breastfeeding?

☐ NO ☐ YES 10. Do you have dermal fillers?

I have read and fully understand the information regarding the COVID-19 vaccine and have been given the opportunity to ask questions. My signature below also acknowledges receipt and review of the VHA Notice of Privacy Practices, effective date September 30, 2019. I certify the information I provided is true and correct. I understand that it's a crime to give false information. Penalties may include a fine, imprisonment or both.

Date _____ **Signature** _____

To be Completed by Vaccinator/Healthcare Provider

☐ *Emergency Use Authorization (EUA) Reviewed/Provided*

Date _____

Site: ☐ Left Deltoid ☐ Right Deltoid

Vaccine: ☐ Pfizer ☐ Moderna ☐ Janssen (J&J)

Expiration Date _____

Lot No. _____

☐ *Charted in CPRS* **Vaccine Administrator** _____