SANTA CLARA VALLEY MEDICAL CENTER
Hospital & Clinics

MRN (Medical Record Number):

COVID-19 Vaccine Screening Form

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

Date of Birth: _____

Emergency Contact Name and Phone number: _____

Have you ever received a dose of the COVID-19 Vaccine? ☐ Yes ☐ No

If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Other _____

Are you here today for an additional dose of vaccine after completing 2 doses of Pfizer or Moderna? ☐ Yes ☐ No

If you answer "yes" to any question below, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked.

	Yes	No
1. Do you have a bleeding disorder or are you taking a blood thinner other than Aspirin? (For "yes" answers, pressure will be held on the arm by the vaccinator after the injection)		
2. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to anything? This would include food, pet, environmental, or oral medication allergies. (For "yes" answers, 30 min observation is required)		
3. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (For "yes" answers, 30 min observation is required)		
"Yes" answers to the questions below will be addressed by an RN on site per BRN nursing protocol.		
4. Have you ever had an allergic reaction to any of the following? • Previous dose of the COVID-19 Vaccine • Component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures • Polysorbate 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. In the last 3 months, have you had a Stem Cell/Bone Marrow Transplant or undergone Cellular Therapy (CAR T Cell therapy)?		
6. Are you currently undergoing chemotherapy for acute leukemia?		
7. Have you received antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 in the last 90 days?		

If you have dermal fillers: You may develop temporary swelling at or near the filler injection site after a dose of a COVID-19 vaccine. Please contact your healthcare provider if swelling develops at or near the site of dermal filler following vaccination.

If you have a weakened immune system: The vaccine effectiveness in immunocompromised populations is unknown. You may have a reduced immune response to the vaccine. Some Rheumatologists recommend altering immunosuppressant medications. Please speak to your healthcare provider before proceeding to vaccination if you would like to discuss this further.

If you are pregnant or breastfeeding: The FDA authorized COVID-19 vaccines for pregnant and breastfeeding people. They are not live vaccines. Based on current knowledge, experts believe that the benefits of receiving Covid-19 vaccines outweigh any known or potential risks to the pregnant/lactating person or the fetus/baby.

Office Use Only:		Revised 11/1/2021
Notes:	☐ Thin Needle +2 min Compression	☐ 30 Minute Observation

COUNTY OF SANTA CLARA
Health System

[Patient Sticker/Demographics]

CONSENT TO COVID-19 VACCINATION

The County of Santa Clara is offering COVID-19 vaccination to individuals who meet State of California criteria for vaccination. There is no cost to you for vaccination and insurance is not required. However, if you have health insurance that covers this service, your insurance may be billed.

CONSENT
I have been provided with and have read or had explained to me the Fact Sheet for the COVID-19 vaccine that I am receiving (or if legal representative, the person I am representing is receiving). I have had an opportunity to ask questions, which have been answered to my satisfaction. I understand the risks and benefits of receiving the COVID-19 vaccine and request that the vaccine be given to me / the person for whom I am the legal representative. I understand that my vaccination will be entered into the local California Immunization Registry (CAIR), which will allow for coordinated care between my health care providers.

ASSIGNMENT OF INSURANCE/MEDICAL BENEFITS
I irrevocably assign and transfer to the County all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment includes assigning and authorizing direct payment to the County of all insurance and health plan benefits payable for this outpatient service, at a rate not to exceed the charges listed in the charge description masters. I agree that the insurer or plan's payment to the County pursuant to this authorization shall discharge its obligations to the extent of such payment. I agree to cooperate with, and take all steps reasonably requested by, the County to perfect, confirm, or validate this assignment.

NOTICE OF PRIVACY PRACTICES
I hereby acknowledge receipt of the ***Notice of Privacy Practices (NPP)*** of the County of Santa Clara Health System. Our NPP gives you information about how we may use and disclose your medical or protected health information. Our NPP is subject to change. If we change our notice, we will post the revised version in our facilities and on our website here: https://www.scvmc.org/sites/g/files/exjcpb911/files/Notice%20of%20Privacy%20Practices%20-%20English%20Mar%202019%20final.pdf

ACKNOWLEDGEMENT REGARDING SUBSEQUENT DOSES
I consent to receive email or text messages with reminders to schedule an appointment for a subsequent dose, if needed. I understand that such messages will not be sent securely.

I certify that I am the patient, the patient's legal representative, or otherwise authorized by the patient to sign the above and accept its terms on the patient's behalf.

Signature *(patient or legal representative)*: _____

Patient Name:_____ Date:_____

Legal Representative printed name (if applicable):_____ Phone:_____

If not patient, indicate relationship to patient: _____

Moderna Fact Sheet
(Paper copy available upon request)

Pfizer Fact Sheet
(Paper copy available upon request)

Pfizer 5-11 Fact Sheet
(Paper copy available upon request)

Johnson & Johnson Fact Sheet
(Paper copy available upon request)

SANTA CLARA VALLEY MEDICAL CENTER
Hospital & Clinics

COVID-19 Vaccine Intake Form
Patient Information

First Name:	Middle Initial:	Last Name:
Date of Birth (mm/dd/yyyy):	Gender: ☐ Male ☐ Nonbinary ☐ Female ☐ Unknown	Phone Number: ☐ Home ☐ Mobile
Address (Street, City, State, Zip Code):		
Email Address:		Preferred Language:

Race		Ethnicity
☐ (1) Alaska Native	☐ (15) Hispanic or Latino	☐ (1) Central American
☐ (2) Asian, Cambodian	☐ (16) Native American	☐ (2) Cuban
☐ (3) Asian, Chinese	☐ (17) Pacific Islander	☐ (3) Dominican
☐ (4) Asian, Filipino	☐ (18) Pacific Islander, Guamanian	☐ (4) Latin American
☐ (5) Asian, Indian	☐ (19) Pacific Islander, Hawaiian	☐ (4) Mexican
☐ (6) Asian, Japanese	☐ (20) Pacific Islander, Samoan	☐ (5) Not Hispanic or Latino
☐ (7) Asian, Korean	☐ (21) Patient Declined/ Unable to specify	☐ (6) Other Hispanic or Latino
☐ (8) Asian, Laotian	☐ (22) White, Arab	☐ (7) Patient Declined/Unable to Specify
☐ (9) Asian, Other	☐ (23) White, European	☐ (8) Puerto Rican
☐ (10) Asian, Pakistani	☐ (24) White, Middle Eastern or North African	☐ (9) South American
☐ (11) Asian, Vietnamese	☐ (25) White, North American	☐ (10) Spaniard
☐ (12) Black, African-American	☐ (26) White, Other	
☐ (13) Black, African		
☐ (14) Black, Other		

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Data Collection for COVID-19 Vaccine Equity - Patient Information

Please check any of the items below if they apply to you:

I am a Migratory/Seasonal Agricultural Worker	☐ Yes ☐ No ☐ Declined to Answer
I am experiencing homelessness	☐ Yes ☐ No ☐ Declined to Answer
I receive Section 8 Housing subsidy	☐ Yes ☐ No ☐ Declined to Answer
I have limited ability to speak in English or read/write in English	☐ Yes ☐ No ☐ Declined to Answer

Do you have any type of disability including physical disability or mobility limitations, mental health disability, visual/hearing disability, intellectual or learning disability? ☐ **Yes** ☐ **No** ☐ **Declined to Answer**

Por favor, marque cualquiera de los siguientes puntos que le correspondan:

Soy un trabajador agrícola migratorio o de temporada	☐ Si ☐ No ☐ Declino responder
No tengo hogar	☐ Si ☐ No ☐ Declino responder
Recibo un subsidio de vivienda de la Sección 8	☐ Si ☐ No ☐ Declino responder
Tengo una capacidad limitada para hablar en inglés o leer/escribir en inglés	☐ Si ☐ No ☐ Declino responder

¿Tiene algún tipo de discapacidad, incluida la discapacidad física o las limitaciones de movilidad, la discapacidad mental, la discapacidad visual/auditiva, la discapacidad intelectual o de aprendizaje?
☐ **Sí** ☐ **No** ☐ **Declino responder**

Xin đánh dấu các mục dưới đây, nếu có mục nào đúng với quý vị:

Tôi là Nhân Viên Nông Nghiệp Theo Mùa/ Di Động	☐ Đúng ☐ Không ☐ Không trả lời
Tôi là người vô gia cư	☐ Đúng ☐ Không ☐ Không trả lời
Tôi nhận Trợ Cấp Gia Cư theo Section 8	☐ Đúng ☐ Không ☐ Không trả lời
Tôi nói, đọc và viết tiếng Anh rất hạn chế	☐ Đúng ☐ Không ☐ Không trả lời

Quý vị có bị khuyết tật gì, như mất năng lực thể chất, khó di chuyển, bệnh tâm trí, mất khả năng thị giác/thính giác, hoặc mất khả năng về tri thức hoặc học vấn? ☐ **Có** ☐ **Không** ☐ **Không trả lời**

請檢查以下任何一項是否適用於您：

我是遷移性/季節性農業工作者	☐ 是 ☐ 否 ☐ 拒絕回答
我正在無家可歸	☐ 是 ☐ 否 ☐ 拒絕回答
我領取第 8 款(Section 8)住房補貼	☐ 是 ☐ 否 ☐ 拒絕回答
我的英語口語或英語讀寫能力有限	☐ 是 ☐ 否 ☐ 拒絕回答

您是否有任何類型的殘障，包括身體殘障或移動受限，
精神心理健康障礙，視覺/聽覺障礙，智力或學習障礙 ☐ **是** ☐ **否** ☐ **拒絕回答**

COVID-19 Vaccination Instructions for Patients

Side effects that have been reported with COVID-19 vaccines include:

- Injection site reactions: pain, tenderness and swelling of the lymph nodes (glands) in the same arm of the injection, swelling (hardness) and redness
- General side effects: fatigue, headache, muscle pain, joint pain, chills, nausea and vomiting, and fever

If you have any side effects from the vaccine you received today that bother you or do not go away, please call your healthcare provider or Valley Connection at 888-334-1000.

You can register for V-safe which is offered by the Center for Disease Control (CDC). V-safe is a smartphone-based tool that uses text messaging and web surveys to provide personalized health check-ins after you receive a COVID-19 vaccine. Through V-safe, you can quickly tell CDC if you have any side effects after getting a COVID-19 vaccine. Depending on your answers to the web surveys, someone from CDC may call to check on you and get more information. V-safe will also remind you to get your second COVID-19 vaccine dose if you need one.
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafe.html

V-Safe QR Code:

There is a small chance that the COVID-19 vaccine could cause a severe allergic reaction.
A severe allergic reaction would usually occur within a few minutes to one hour after getting the vaccine. Signs of a severe allergic reaction can include:

- Difficulty breathing
- Swelling of your face and throat
- A fast heartbeat
- A bad rash all over your body
- Dizziness and weakness

Moderna Fact Sheet
(paper copy available upon request)

Pfizer Fact Sheet
(paper copy available upon request)

Johnson & Johnson Fact Sheet
(paper copy available upon request)

8.25.21