Dose #_____

LITTLETON PEDIATRIC MEDICAL CENTER

Covid-19 Vaccine Administration and Screening Form

Patient's Last Name:_____ Patient's First Name:_____

Patient's Date of Birth: ___/___/____ Age Range: ☐6m-4y ☐5-11y ☐12+y

Insurance Eligibility (select all that apply):

- ☐ Private Insurance (through employer or self) or CHP+
- ☐ Healthshare Plan
- ☐ Medicaid
- ☐ No Insurance
- ☐ Alaskan Native/American Indian

Health Screening Questions:

	Yes	No
1. Are you sick today?	☐	☐
2. Do you have a serious allergy to food, a vaccine component, or latex?	☐	☐
3. Have you ever had a serious reaction to a previous dose of vaccine or any medication?	☐	☐
4. Have you ever had a severe allergic reaction to any component of either the Pfizer-BioNTech or the Moderna vaccine?	☐	☐
5. Are you pregnant, or is there a chance you may become pregnant in the next 14 days?	☐	☐
6. Have you received any vaccinations in the last 14 days?	☐	☐
7. Have you been ill with or recovered from COVID in the past 3 months?	☐	☐
a. If YES, did you receive COVID antibody therapy? Yes / No		
8. Do you have any of the following illnesses or conditions? *Chronic lung disease (including asthma), heart disease, diabetes, brain/spinal/or muscle illness that causes swallowing or lung problems, immune system problems caused by medication and/or HIV, kidney disease, liver disease, blood disorders*	☐	☐

Authorization to Administer COVID Vaccine

I have read or had explained to me, and I understand the risks and benefits of receiving the vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I hereby release this provider, its employees, and its volunteers from any liability for any results which may occur from the administration of this vaccine.

Patient/Parent/Guardian Signature:_____ Date:_____

Prescriber: ☐Kyriazi ☐Gin ☐Snelling ☐Koto
☐Froehlke ☐Nelson ☐Stutzman

STOP - DO NOT WRITE BELOW THIS LINE

Pfizer Dose: ☐0.2ml ☐0.3ml Lot #_____ Site: ☐LA ☐RA ☐LT ☐RT

Date Administered:_____ Administered by:_____RN