

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 _____

Vaccine: Pfizer Moderna Janssen (J&J)

Site: Left Deltoid Right Deltoid

Expiration Date _____

Lot No. _____

Charted in CPRS Vaccine Administrator _____