

2021 VHA SAVE LIVES ACT COVID-19 VACCINATION WORKSHEET

Name

Last 4

Date of Birth

Address

City

State

Zip Code Email

Phone

Birth Sex: Male Female

Gender:

Eligibility

☐ Non-Enrolled Veteran

☐ Spouse

☐ Caregiver

Other:

For Spouse/Caregiver/Other Registration Only:

Veteran Name:

For Veteran Registration Only:

Branch of Service:

Date of Separation:

Total Time Active Duty:

Character of Discharge:

Race:

☐ American Indian/Alaska Native

☐ Asian

☐ Hawaiian/Pacific Islander

☐ Black/African American

☐ White

☐ Other

☐ Decline to Answer

Ethnicity:

☐ Hispanic or Latino

☐ Not 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? ☐ NO ☐ YES

• 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: