WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

Appointment Date: __/__/__ Time: _____

2020-2021 Offsite COVID-19 Screening Questionnaire ENGLISH

1001 East 9th Street, Reno NV, 89512

Complete the Following for the Person Who is Being Vaccinated:

PATIENT Name: FIRST_____ MIDDLE_____ LAST_____

Phone: (_____) - _____ - _____ Birth Date: _____/_____/_____ Age: _____ Sex: ☐ F ☐ M Weight: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY Contact & phone _____ Employer:_____ Occupation: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Not known

Race: (Check all that apply): ☐ White ☐ Black ☐ Asian ☐ Am Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Other/Mixed ☐ Unknown

COVID-19 Vaccination Series:

Are you here to receive: ☐ **DOSE 1 OR** ☐ **DOSE 2** *Date dose 1 was received: ____/____/_____ **Manufacturer: (circle)** Pfizer/Moderna/other

If dose 2 | ***(STAFF-verify the interval) _____21 days (Pfizer) _____ 28 days (Moderna) _____Other**

Questions for the Person Getting Vaccinated:

		NO	YES
1.	Are you sick today? If yes, what are your symptoms?	☐	☐
2.	Are you 18 years or older?	☐	☐
3.	Have you or anyone in your household been exposed to, diagnosed with, or has been placed in quarantine for COVID-19 in the past 14 days?	☐	☐
4.	Have you received passive antibody therapy as treatment for COVID-19 in the past 90 days?	☐	☐
5.	Have you received any vaccinations in the past 2 weeks? If yes, please list:	☐	☐
6.	Have you ever had a **severe** allergic reaction (anaphylaxis) to a vaccine or injectable medication in the past? If yes, what vaccine/medication?	☐	☐
7.	Have you ever had a **severe** reaction (anaphylaxis) to any medications, latex, foods, pets or insects that required the use or treatment with epinephrine or an EpiPen? Please list allergies:	☐	☐
8.	Are you immunocompromised or receiving immunosuppressant therapy?	☐	☐
9.	Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐
10.	For women: Are you pregnant or breastfeeding? Please circle one (not contraindicated)	☐	☐

Read Below and Sign:

I hereby acknowledge that I have received the Emergency Use Authorization (EUA) vaccine fact sheet and the Notice of Health Information Practices. I have had the opportunity to ask questions for the immunization to be administered to me or the person named above, for whom I am authorized to make this request. I agree to allow my immunization information to be stored and accessed by authorized users in "Nevada's Web IZ". I also agree to have my blood tested or the person named above, for whom I am authorized to make this request, for blood borne bacteria and viruses that may result in disease in the event a person is exposed to my blood or body fluids, or to the person who is named above. By signing this document, I declare that the above information is true and accurate to the best of my knowledge.

Signature: X_____ **Date:**_____

Parent/Guardian signature required if under 18 years old

For Clinic Use only: Do not write below

VACCINE	CVX	CPT	DATE GIVEN	LOT #	EXP. DATE	RT	SITE	DOSE	CLINIC	ADMINISTERED BY	FACT SHEET DATE
Pfizer (PFR)	208	91300				IM	LD RD	0.3 mL	WCHD		12/2020
Moderna (MOD)	207	91301				IM	LD RD	0.5 mL	WCHD		12/2020

WebIZ # _____ **Patagonia #**_____ **Demo/Ins By:**_____ **IZ By:**_____ **Scanned By:**_____

NAME _____ DOB _____

Ethnicity

Please check off *all applicable* boxes.

- ❑ Hispanic or Latino
- ❑ Non-Hispanic or Non-Latino
- ❑ Not known

Race

Please check off *all applicable* boxes.

- ❑ Asian
- ❑ Black
- ❑ Native Hawaiian or Pacific Islander
- ❑ White
- ❑ Other
- ❑ Mixed
- ❑ Unknown

Personnel Groups

Please check off the personnel group that best describes you.

- ☐ Frontline Healthcare Personnel (Acute Care Hospital Setting)
- ☐ Healthcare Personnel in a Long-Term Care Facility
- ☐ Frontline Healthcare Personnel (Psychiatric/Substance Abuse Hospital Setting)
- ☐ Emergency Medical Service Personnel (EMS)
- ☐ Frontline Public Health Personnel
- ☐ Laboratory Workers
- ☐ Pharmacists/Pharmacy Technicians
- ☐ Healthcare Personnel (Outpatient Setting, includes dentists, optometrists, etc.)
- ☐ Home Healthcare Personnel
- ☐ Nevada Department of Corrections Personnel/Juvenile Detention Center Staff
- ☐ Frontline Law Enforcement Personnel (includes Police Departments, Sheriff's Offices and NV Highway Patrol)
- ☐ Deployed and Mission Critical Personnel
- ☐ State Emergency Operations Center Personnel
- ☐ Other Frontline Personnel (please specify priority group category):_____