



GHC Covid-19 Vaccine Information

V SAFE



- 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 vaccination. Through v-safe, you can quickly tell CDC if you have any side effects after getting the COVID-19 vaccine. Depending on your answers, someone from CDC may call to check on you. And v-safe will remind you to get your second COVID-19 vaccine dose if you need one.

Sign up with your
smartphone's browser at
vsafe.cdc.gov

OR

Aim your smartphone's
camera at this code



VACCINE CHOICE

- Girdwood Health clinic will be administering Covid-19 Vaccine allocated by the State of Alaska. Vaccine options may vary based on supply availability.
- An EUA fact sheet will be provided for your review at the time of your vaccine appointment.

RESOURCES

- For information on Covid-19 Vaccine options, see the links below:

Pfizer

<https://www.pfizer.com/>

Moderna

<https://www.modernatx.com/covid19vaccine-eua/>

Janssen (Johnson & Johnson)

<https://www.janssen.com/covid-19-vaccine>

Other Covid-19 Vaccine Information:

<https://www.cdc.gov/vaccines/covid-19/index.html>

**Girdwood Health Clinic
Registration and Informed Consent for COVID-19 Immunization**

Date: _____ Emergency Use Authorization Fact Sheet received? Yes No

PARTICIPANT'S INFORMATION

First Name	Middle Initial	Last Name
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
Date of Birth	Age	
Mailing Address: Street, City, State, Zip		
Cell Phone	Home Phone	
Race	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other	
Check all that apply	<input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Decline	
Hispanic?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline	
Insurance Type	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Tricare <input type="checkbox"/> Other Private Insurance <input type="checkbox"/> Uninsured	

Do you have any of the following Health Conditions? Asthma - Serious Heart Condition - Liver Disease - Chronic Lung Disease - Diabetes - Severe Obesity - Immunocompromised Yes No Unknown

Occupation

<input type="checkbox"/> Construction, Landscaping, Other trades <input type="checkbox"/> First Responders-Fire, Police, EMT <input type="checkbox"/> Healthcare-Direct Patient contact <input type="checkbox"/> Healthcare-No direct Patient contact <input type="checkbox"/> Office worker-manager, supervisor, employee, clerical <input type="checkbox"/> Oil Industry <input type="checkbox"/> Plant workers, Manufacturing, Machine Operators, and assemblers <input type="checkbox"/> School employee or contractor	<input type="checkbox"/> Seafood Industry <input type="checkbox"/> Service-entertainment <input type="checkbox"/> Service- Restaurants, Bars, Catering, Fast Food <input type="checkbox"/> Service- Retail, cosmetology, massage, elective services <input type="checkbox"/> Service- Transportation <input type="checkbox"/> Service- Tourism <input type="checkbox"/> Skilled Agriculture <input type="checkbox"/> Other
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Prevaccination Checklist for Covid-19 Vaccine			
The following questions will help us determine if there is any reason you should not get the Covid-19 vaccine today. If you answer "yes" to any questions it does not mean you should not be vaccinated. It just means additional questions may be asked.	YES	NO	Don't Know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
<ul style="list-style-type: none"> • If yes, which vaccine product did you receive? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another product 			
3. Have you ever had an allergic reaction to: (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.)			
<ul style="list-style-type: none"> • A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for a colonoscopy 			
<ul style="list-style-type: none"> • Polysorbate, which is found in some vaccines, film coated tablets and intravenous steroids. 			
<ul style="list-style-type: none"> • A previous dose of COVID-19 vaccine 			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (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. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Informed Consent: *Please read and sign.*

My signature below indicates that:

- I have voluntarily chosen to receive the vaccination and consent to the administration.
- I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient or am authorized to consent on behalf of the client.
- I have read, or have had read to me, the Vaccine Information Statement(s) (“VIS”) or Emergency Use Authorization (“EUA”) provided for the vaccine(s) to be administered.
- I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.
- I understand the benefits and risks of the vaccine(s).
- I will immediately alert the provider of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine.
- I understand I should remain in the area for 15 minutes after the vaccination for observation or 30 minutes if I have any history of severe allergic reaction or anaphylaxis.

Parent/Guardian/Authorized Representative Print _____

Parent/Guardian/Authorized Rep. Signature _____ Date _____

OFFICE USE ONLY

Vaccine	1 st /2 nd dose	VFC/AVAP	Admin Site	Lot #	Manufacturer	EUA Fact Sheet Date
Moderna COVID-19 vaccine 0.5 mL		V07			MOD	
Janssen (J&J) COVID-19 vaccine 0.5 mL		V07			JSN	
Pfizer COVID-19 vaccine 0.3 mL		V07			PFR	

Record Card provided to patient **Provider name (Print)** _____
Provider name (Signature) _____

Adverse Event _____ VAERS Report completed _____

*Adverse Event Type Local Syncope Anaphylaxis

*(If there was an adverse event, an event type must be selected.)

Arrival Time _____ Exit Time _____

Administration Sites	
Left Deltoid IM	LDI
Right Deltoid IM	RDI

EHR: _____ VacTrAK: _____ Next Dose: _____