California Immunization Registry (CAIR) COVID-19

I agree to allow **my** (or my child's) immunization record/TB test record to be shared with other healthcare providers, agencies, or schools in the California Immunization Registry.*

Name (First Last)	Date of Birth	Sex	Mother's First Name	Mother's Maiden Name
		M / F		

Race & Ethnicity (Check ALL that Apply)

☐ Alaskan Native or American Indian ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Black or African-American ☐ White ☐ Other

☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino**

Mailing Address:

City, State, ZIP:

If you are a homeless youth please verify the following:

☐ I am 15, 16 or 17 years old
☐ I do not live with my parents or legal guardian
☐ I make my own financial decisions

Phone:

☐ **I Consent to Receive Texts from Text Illness Monitoring (TIM)**

My signature below is acknowledgement that I have received or been offered a copy of the **Emergency Use Authorization** and have read, or had explained to me, the information contained about the disease and vaccine given today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and request that the vaccine recommended be given to me or the person named above for whom I am authorized to make this request. I have received, or been offered, the Tehama County Health Services Agency (TCHSA) **Notice of Privacy Practices** on this date. The TCHSA Notice of Privacy Practices provides information about how TCHSA may use and disclose your protected health information. TCHSA encourages you to read it in full.

Client Signature OR parent/guardian's signature: ☐ SELF ☐ PARENT/GUARDIAN

X **Date**:

☐ *I decline to allow **my** (or my child's) immunization record/tuberculosis (TB) screening test record to be shared with other health care providers, agencies, or schools in the California Immunization Registry. **Note**: The immunization record/TB Tests may still be recorded in the registry for use by this office. By law, public health officials can also access immunization/TB Test records in the case of a public health emergency.

STAFF TO COMPLETE:		**PATIENT ID:**	
☐ **1st Dose Date:**	☐ **Moderna** ☐ **Pfizer** ☐ **J&J / Janssen**	**CAIR #**:	
☐ **2nd Dose Date:**	**LOT #:**	**Site:** LD RD	**Nurse**:

ENTERED

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name _____

Age _____

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 question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked.
If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ 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.)			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
• Polysorbate			
• 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, polysorbate, or any vaccine or injectable medication? This would include food, pet, 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?			

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists