



**Maine CDC Public Health Nursing**  
**HEALTH SCREEN & CONSENT FORM – COVID-19 Vaccine**  
 Please answer the following questions about the person to be vaccinated.

Name:	Date of Birth:	Age:	Preferred Language:
Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Public <input type="checkbox"/> Private	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary/X <input type="checkbox"/> Transgender <input type="checkbox"/> Prefer not to disclose <input type="checkbox"/> Other _____		
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other Race	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	
Street Address:	City/Zip:	Phone:	

<i>Please answer the following questions about <u>the person named above.</u></i>	Yes	No
1. Have you ever received a dose of COVID-19 vaccine? <i>If yes, documentation is required.</i>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you had, in the last 10 days, fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been advised to isolate or quarantine at this time?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you moderately to severely immune compromised?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis)? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital.	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had an allergic reaction to a previous COVID-19 vaccine? For example, did you have hives, swelling, or wheezing within 4 hours of vaccination?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have a history of myocarditis or pericarditis?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you received passive antibody therapy in the last 90 days?	<input type="checkbox"/>	<input type="checkbox"/>

**FOR VACCINE RECIPIENTS <18 YEARS OF AGE, GUARDIANS PLEASE CHECK ONE OF THE FOLLOWING BOXES:**

My child’s immunizations **can be done without** my presence.  
 My child’s immunizations **can only be done with** my presence.

**PERMISSION TO VACCINATE**

- I was given a copy of the Emergency Use Authorization Fact Sheet, which I have read or had this fact sheet explained to me, and I understand the benefits and risks of the COVID-19 vaccine.
- I understand that a record of this vaccination will be entered into the Maine Immunization Information System, ImmPact.
- I understand that I am advised to stay on site today for at least 15 minutes post-vaccination.
- **I give permission for the COVID-19 vaccine to be given to the person named above by signing below.**

X \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature of guardian of person to be vaccinated or Signature of adult to be vaccinated

X \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature of interpreter

**FOR OFFICE USE ONLY:**

Dose	Date Dose Administered	Vaccine Manufacturer	Lot Number	Dose Volume	Signature and Credentials of Vaccine Provider	Injection Site - Deltoid	Route	EUA date
Dose 1 _/_/_/	/ /					Left	<input type="checkbox"/> IM	
Dose 2 _/_/_/						Right		
Dose 3 _/_/_/								
COVID-19 Vaccination Card Completed: <input type="checkbox"/> Y <input type="checkbox"/> N						Temperature:		