NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

COVID-19 Recipient Vaccination Questionnaire

PERSONAL AND CONTACT INFORMATION

Please fill out ALL the information below

First Name: _____ Last Name: _____

RISK LEVEL INFORMATION

Are you responsible for caring/cleaning in areas with COVID Patients?

- ☐ Yes
- ☐ No

Are you responsible for performing tasks with high risk of aerosolization (intubation, bronchoscopy, suctioning, invasive dental procedures, invasive specimen collection, CPR)?

- ☐ Yes
- ☐ No

Are you responsible for handling decedents with COVID?

- ☐ Yes
- ☐ No

Are you planning to be responsible for administration of the Vaccine?

- ☐ Yes
- ☐ No

For Provider: If Recipient answers Yes to any of these questions, please enter Risk = High. If No to all question, please enter Risk = Low

What is the name of the organization you work/reside in? _____

What is the type of organization listed above? (Please Select One):

- ☐ Public Health Department
- ☐ Family or Internal Medicine
- ☐ Geriatric Medicine
- ☐ Hospital
- ☐ Pediatrician
- ☐ STD/HIV Services
- ☐ Urgent Care
- ☐ Long-Term Care Facility
- ☐ Family Planning
- ☐ Pediatrician
- ☐ Pharmacy
- ☐ Other Health Care Facility
- ☐ Home / Personal / Community Aid
- ☐ Dentist
- ☐ Homeless or Crisis Care
- ☐ CHC / FQHC / RHC
- ☐ Group or Congregate Living
- ☐ Migrant or Refugee Services
- ☐ Mortician / Funeral Home
- ☐ Childcare / School / College
- ☐ Prison
- ☐ Emergency Services
- ☐ Government Agency
- ☐ Religious Organizations
- ☐ Tribal or Indian Health Services
- ☐ Retail / Grocery
- ☐ Food Processing, Preparation, or Serving
- ☐ Transportation
- ☐ Manufacturing / Farming
- ☐ Construction
- ☐ Other

For Provider: If Specific Employer cannot be found in CVMS, Select Generic Version of Above Employer Type as Employer

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Do you work or reside in the organization listed above?

- ☐ Work
- ☐ Reside
- ☐ Both

For Provider: If Work or Both chosen, please select Type = Employee. If Reside Chosen = Individual

Date of Birth: _____

Email: _____

- ☐ I do not have an email/ I do not wish to disclose this information

Street: _____

City: _____ **County:** _____

State: _____ **Zip Code:** _____

Home Phone: _____ **Mobile Phone:** _____

Communication Preference:

- ☐ Email
- ☐ SMS
- ☐ Both
- ☐ None

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Other

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Gender:

- ☐ Male
- ☐ Female
- ☐ Unknown

Are you an Essential Frontline Worker (Police, Food Processing, Teachers, etc.)?

- ☐ Yes
- ☐ No

If yes, what is the name of your employer? _____

Do you reside or work in a long-term care/assisted living facility?

- ☐ Yes
- ☐ No

If yes, what is the name of the facility? _____

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Are you a member of a state or federal recognized tribal nation?

- ☐ Yes
- ☐ No

If yes, what is the name of the community?_____

MEDICAL INFORMATION

Review the below list of conditions known to increase risk of severe illness to COVID-19:

- Asthma
- Cancer
- Cerebrovascular Disease
- Chronic Obstructive Pulmonary Disease
- Chronic Kidney Disease
- Cystic Fibrosis
- Hypertension or High Blood Pressure
- Type 1 Diabetes Mellitus
- Type 2 Diabetes
- Immunocompromised from solid organ transplant
- Immunocompromised state (weakened immune system)
- Liver Disease
- Neurologic conditions, such as Dementia
- Obesity
- Overweight (BMI > 25 kg/m2, but < 30 kg/m2)
- Pregnancy
- Pulmonary Fibrosis (having damaged or scarred lung tissues)
- Sickle Cell Disease
- Smoker
- Thalassemia (a type of blood disorder)

How many conditions known to increase risk of severe illness from COVID-19 do you have?

- ☐ None
- ☐ 1
- ☐ 2 or more

CONSENT

☐ I certify that I am: (a) at least 18 years of age (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an "applicable Provider"), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine. I understand that the health data shared within this questionnaire will be used to determine my eligibility for receiving the COVID-19 vaccination and further determine timing of when the vaccine will be made available to me.

_____

Signature of Recipient

TOE RIVER HEALTH DISTRICT
Avery, Mitchell, & Yancey County Health Departments

Diane Creek, MSW
Health Director

Julia Sherrill, MD & Frank Craig, MD
Medical Directors

North Carolina Public Health
Jim Deaton, Chair
Board of Health

Patient Name:_____

Age:_____

Prevaccination Checklist for COVID-19 Vaccines

For Vaccine Recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If a question **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.**is not clear, please ask your healthcare provider to explain it.

Prescreening Questions	Yes	No	I do not know
1. Are you feeling sick?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? Pfizer Moderna			
3. Have you ever had an allergic reaction to the following items?			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonscopy 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?			
5. Have you ever had a severe allergic reaction (anaphylaxis) to something?			
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:_____

TOE RIVER HEALTH DISTRICT COVID-19 CONSENT FORM

Please complete this form and return with a copy of your Medicare, Medicaid, or Insurance Card.

PLEASE PRINT: Date of Birth _____ Age _____

Name _____ _____

Last First Middle Maiden

Social Security Number: _____

Mailing Address _____

City _____ State _____ Zip Code _____

County of Residence _____ Phone # _____

1. Have you had close contact (within 6ft for at least 15 minutes) in the last 14 days with someone diagnosed with COVID-19, or has any health department or health care provider contacted you and advised quarantine? ..... ❑ No ❑ Yes
2. Have you had any of the following symptoms? ..... ❑ No ❑ Yes

(Fever, chills, shortness of breath or difficulty breathing, new cough, new loss of taste or smell, congestion/runny nose, headache, diarrhea, nausea/vomiting)

3. In the last two weeks have you had any immunizations? ..... ❑ No ❑ Yes
4. Do you have a bleeding disorder? ..... ❑ No ❑ Yes
5. Have you recently or are you currently taking anticoagulants (blood thinners)? ..... ❑ No ❑ Yes
6. If you answered yes to questions 4 or 5, do you have written permission from your primary care provider to receive the COVID-19 vaccine? ..... ❑ No ❑ Yes
7. Have you had any facial fillers (Botox, etc.)? ..... ❑ No ❑ Yes

Immunization Administered:

❑ COVID-19 Vaccine dose 1
❑ COVID-19 Vaccine dose 2

Date of second COVID-19 vaccine dose to be administered **Date** _____

❑ COVID-19 Vaccine verification card provided to patient
❑ Patient informed of V-Safe app
❑ COVID-19 VIS given

I authorize payment of the above named benefits to Toe River Health District for services received. I acknowledge that a copy of the Toe River Health District Notice of Privacy Practices was made available to me.

Patient's or Authorized Person's Signature _____ **Date** _____

FOR OFFICE USE ONLY:

TRHD USE ONLY							
	COVID-19	IMM DATE	DOSAGE ❑ 0.50 ml	ROUTE IM	SITE ❑ LD ❑ RD	MFGR Moderna	LOT #
	Nurse's Signature _____					Expiration Date:	
						Data Entry Date/Initials _____	

CVMS: _____ CureMD: _____

Label

Toe River Health District services and employment opportunities are offered to all people regardless of race, color, national origin, sex, religion, age, or disability.
Disposition: As POHR Manual destroy form in office after three years.