COVID Vaccine Screening Form

101 Grove St, Room 102, San Francisco, CA 94102
(415) 554-2625 www.TravelClinicSF.org

(PLEASE PRINT)
NAME: (FIRST)______________________ (LAST)______________________

☐ I have a different legal name ______________________

AGE: _____ BIRTHDATE: ____/____/______ CELL PHONE: (_____) ______-__________ EMAIL: ______________________

ADDRESS: (STREET)______________________ (CITY)______________________ (ZIP) __________

SEX AT BIRTH: ☐M ☐F **GENDER IDENTITY:** ☐M ☐F ☐Trans Male ☐Trans Female ☐Genderqueer / Gender non-binary ☐Not Listed

SEXUAL ORIENTATION: ☐Bisexual ☐Gay/Lesbian/Same-gender loving ☐Straight/Heterosexual ☐Questioning/unsure ☐Decline to state ☐Not listed: ______

RACE (REQUIRED): ☐AFRICAN AMERICAN ☐ AMERICAN INDIAN ☐ASIAN ☐OTHER ☐PAFICIC ISLANDER ☐WHITE

Ethnicity (Required) : ☐HISPANIC OR LATINO ☐**NON** HISPANIC OR LATINO ☐UNKNOWN

PLEASE ANSWER ALL QUESTIONS BELOW	Yes	No	Not Applicable
1. I am here for the **Moderna** covid vaccine and I am at least 18yrs of age **Age:** _______			
2. I am here for the **Pfizer** covid vaccine and I am at least 12yrs of age **Age:** _______			
3. Have you ever received a COVID-19 vaccine?			
4. Are you allergic to any of the vaccine components or to polysorbate? (Turn page over to see a list, or scan the QR code) PFIZER MODERNA			
5. Have you had a severe reaction to any COVID-19 vaccine?			
6. Have you ever had a severe allergic reaction to any other vaccine or to any injected medication?			
7. Have you received COVID-19 monoclonal antibody or convalescent plasma therapy in the past 90 days?			
8. Do you have a weakened immune system for any reason (HIV, other immune deficiency, medication, or immunosuppressive therapy)?			
9. Are you pregnant, think you may be pregnant, or breastfeeding, or are planning to get pregnant in the next month?			
10. Are you sick today?			
11. Are you on any blood-thinning medication?			
12. Have you ever felt lightheaded or fainted after an injection or blood draw?			
13. Have you been diagnosed with Multisystem Inflammatory Syndrome(MIS-C or MIS-A) after a COVID-19 infection			
14. Do you have a history of heparin-induced thrombocytopenia (HIT)?			
15. Have you received dermal fillers?			

I certify that the above information is correct to the best of my knowledge. I will not hold this clinic or its staff responsible for any errors or omissions that I may have made in the completion of this form.
I have received a copy of the S.F. Dept. of Public Health Notice of HIPAA Privacy Practices. (Back of this form)
I understand the risks and side effects related to receiving this vaccine and I am consenting to get this vaccine.

______________________ ______________________
Signature Date

______________________ ______________________ ______________________
IF CLIENT IS A MINOR: Parent/Legal Guardian Signature | Parent/Legal Guardian's Printed Name | Relation to Minor

STAFF USE ONLY

Vaccine Given:
○ PFIZER
○ MODERNA

LOT:

SITE:

CLINICIAN SIGNATURE:

PFIZER Vaccine Components	**MODERNA Vaccine Components**
Nucleoside-modified messenger RNA (mRNA) encoding SARS-CoV-2 viral spike glycoprotein (S), ((4-hydroxybutyl)azanediyl)bis (hexane-6,1-diyl)bis(2-hexyldecanoate), 2[(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-distearoyl-sn-glycero-3-phosphocholine, Cholesterol, Potassium chloride, Monobasic potassium phosphate, Sodium chloride, Dibasic sodium phosphate dihydrate, Sucrose	Nucleoside-modified messenger RNA (mRNA) encoding the pre-fusion stabilized spike glycoprotein (S) of SARS-CoV-2 virus, SM-102: heptadecan-9-yl 8-((2-hydroxyethyl) (6-oxo-6-(undecyloxy) hexyl) amino) octanoate, Polyethylene glycol [PEG] 2000 dimyristoyl glycerol [DMG], Cholesterol, 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC] , Tromethamine, Tromethamine hydrochloride, Acetic acid, Sodium acetate, Sucrose

SUMMARY DPH NOTICE OF PRIVACY PRACTICES

The attached Notice describes how health information about you may be used and disclosed in the DPH and your rights regarding the use of that information. **Please review this summary and the full Notice carefully.**

DPH Pledge: Employees of the San Francisco Department of Public Health (DPH), its affiliates and contract providers understand that information about you and your health is personal. They are committed to protecting your health information.

Who will follow the rules in this notice: All DPH and contract provider employees, DPH affiliates, as well as staff assigned to DPH by the University of California at San Francisco, must follow these rules.

You have the right to: (please see possible restrictions starting on page 2 in the full Notice)

- Ask to see, read and/or obtain a copy of your health record (charges may be necessary).
- Ask to correct information that you believe is wrong in your health record.
- Ask that your health information not be shared with certain individuals.
- Ask that your health information not be used for certain purposes; for example, research.
- Ask DPH to send copies of your health record to whomever you wish (charges may be necessary).
- Be informed about who has read your record (for reasons other than treatment, payment, and program improvement)
- Specify where and how DPH employees may contact you.
- Receive a paper copy of the full DPH Notice of Privacy Practices.

DPH may use and disclose your health information to improve your treatment.

- To improve the quality of care you receive, your health information may be shared between treatment providers – including health information regarding mental health, substance abuse, HIV/AIDS, sexually transmitted diseases (STD), and developmental disabilities.
- There are circumstances when health information about you will not be shared unless you first give your permission for it to be shared; such as when you receive services in a substance abuse treatment agency.
- See Page 4 in the "Notice of Privacy Practices" for more info. If you have concerns about how your health information might be (or has been) shared, please speak with your provider or call the DPH Privacy Officer at (415) 206-2354.

If you believe your privacy rights have NOT been maintained while receiving DPH services, you may file a complaint with the DPH Privacy Officer at (415) 206-2354. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services' Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, SF, CA 94103. You will not be penalized in any way for filing a complaint.

Notice Regarding Unsecure Data Transmission by Email: DPH email does not provide secure data transmission as defined by HIPAA. Therefore DPH email transmission may not be secure against unauthorized disclosure.

By your signature on the reverse side of this page, you:

- Acknowledge receipt of the San Francisco Department of Public Health "Notice of Privacy Practices." .
- Acknowledge that DPH email may not be secure against unauthorized disclosure, and agree that DPH may send your health information to you via unsecure email, but only upon your specific request to receive such information by email.
- Agree that if the DPH services you received at AITC are to be billed to a third party, then your name, the services to be paid by the third party, and other info necessary to complete the billing, may be disclosed to the third party payor.