Maine CDC Public Health Nursing
HEALTH SCREEN & PERMISSION 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? ☐Yes ☐ No If yes: ☐ Public ☐ Private	Gender: ☐ Male ☐ Female ☐Non-Binary/X ☐Transgender ☐Prefer not to disclose ☐Other _____		
Race: ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐Black or African American ☐White ☐Other Race		Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Non-Latino	
Street Address:	City/Zip:	Phone:	

Please answer the following questions about the person named above.		**Yes**	**No**
Have you ever received a dose of COVID-19 vaccine? *If yes, documentation is required.*		☐	☐
For patients who are pregnant or breastfeeding, have you consulted with your provider about receiving a COVID-19 vaccine? *If you answer no to this question, you cannot be vaccinated at this time.*	**N/A** ☐	☐	☐
1. 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?		☐	☐
2. Have you been advised to isolate or quarantine at this time?		☐	☐
3. 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.		☐	☐
4. Have you ever had a non-severe allergic reaction to a previous COVID-19 vaccine? For example, did you have hives, swelling, or wheezing within 4 hours of vaccination?		☐	☐
5. Have you received passive antibody therapy within the past 90 days?		☐	☐
6. Have you received any other vaccines in the last 14 days?		☐	☐

If you answered "Yes" to any question 1-6, you cannot receive the COVID-19 vaccine *at this time*.

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 Right	☐IM	
Dose 2	COVID-19 Vaccination Card Completed: ☐ Y ☐ N				Temperature:			