WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

WCHD Offsite Child / Teen Screening Questionnaire (ENGLISH)

1001 East 9th Street, Reno NV, 89512

Complete the following for the person who is being vaccinated:

PATIENT Name: First____________________**Middle**____________________**Last**____________________

Phone: (______**) -** _______ **-** __________ **Birth Date:** ________/________/__________ **Age:** ________ **Sex:** ☐ F ☐ M

Month Day Year

Mailing Address: ______________________________ **City:** ______________**State:**_______ **Zip:** ____________

Parent/Guardian Full Name: ______________________________ **Mother's Maiden Name:** ______________________________

Ethnicity: (Check one box)	**Race: (Check all that apply)**	**Social Security Number:**
☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ White ☐ Asian ☐ Black/African American ☐Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Unknown/Declined	________-________-__________ *Required to access immunization records online.

Insurance Status (Check one box only) *Insurance/Medicaid # is required if you are insured!*

☐ **Insured (Has health insurance that covers vaccines): Insurance Company:**______________________________

Insurance Policy ID #:______________________________ **Group # (if one applies):**______________________________

Policy Holder Name:______________________________ **Policy Holder Birth Date:**________/________/__________

Policy Holder Relationship to Patient: ______________________**Social Security # of Policy Holder:**______-______-________

☐ **Medicaid/Nevada Checkup #:**______________________________ ☐ **Uninsured/ No insurance**

Questions for the person getting vaccinated today:

#	Question	No	Yes
1.	Is the person to be vaccinated sick today? If yes, what are their symptoms?	☐	☐
2.	Does the person to be vaccinated have any allergies to medications, foods such as eggs, a vaccine component or latex? (If yes, please list allergies):______________________________	☐	☐
3.	Has the person to be vaccinated ever had a serious reaction to a vaccine in the past? (If yes, please explain):_____________	☐	☐
4.	Does the person to be vaccinated have a long-term health problem with heart, lung, kidney, liver, metabolic disease (such as diabetes), asthma, anemia, another blood disorder, no spleen, complement deficiency, a cochlear implant or spinal fluid leak? (If yes, please circle)	☐	☐
5.	If the person to be vaccinated is a baby, have they had intussusception	☐	☐
6.	Has the person to be vaccinated had a seizure, brain or other nervous system problems including Guillain-Barré Syndrome (GBS)? (If yes, please circle)	☐	☐
7.	Does the child or a family member have cancer, leukemia, HIV/AIDS or any other immune system problems? (If yes, please circle, identify family relationship and explain):______________________________	☐	☐
8.	In the past 3 months, has the person to be vaccinated taken medication that affects their immune system such as, prednisone, other steroids, drugs for the treatment of cancer, rheumatoid arthritis, Crohn's disease, psoriasis or had radiation treatments? (If yes, please circle)	☐	☐
9.	During the past year, has the person to be vaccinated received a transfusion of blood or blood products or been given immune (gamma) globulin? (If yes, please circle)	☐	☐
10.	Is the person to be vaccinated taking antiviral medication such as acyclovir or on long-term aspirin therapy? (If yes, please circle and explain):______________________________	☐	☐
11.	Is the person to be vaccinated pregnant or could she become pregnant within the next month? If pregnant, how far along into the pregnancy? _______________	☐	☐
12.	Has the person to be vaccinated received any vaccinations in the last 4 weeks? (If yes, please list):____________________	☐	☐
13.	Would you like a resource list for help with food, housing, mental health, tobacco and/or substance abuse services?	☐	☐
14.	Does the child have a healthcare provider (doctor)?	☐	☐

Read below and sign:

I have received the Notice of Health information Practices and the Vaccine Information Statement(s) (VIS). I have had the opportunity to ask questions for the immunization(s) to be administered to me or the person named above, for whom I am authorized to make this request.

I agree to allow my immunization information or the person named above, for whom I am authorized to make this request, to be stored and accessed by authorized users in "Nevada's WebIZ" computer system unless I indicate otherwise.

I also agree to have my blood tested or the person named above, for whom I am authorized to make this request, for blood borne bacteria and viruses that may result in disease in the event a person is exposed to my blood or body fluids, or the person named above.

By signing this document, I declare that the above information is true and accurate to the best of my knowledge. I authorize Washoe County Health District (WCHD) to bill my insurance carrier for services received by myself or my dependents. I authorize insurance reimbursement to be paid directly to WCHD. I understand that I am financially responsible for any balances due according to my insurance carrier. I understand and agree that I am financially responsible for any outstanding balance on my account or account(s) of my dependent(s). I authorize the release of any medical or other information necessary to process insurance claims and I agree to allow my medical records to be shared within WCHD programs.

Signature: X____ **Date:**_________________

Parent/Guardian signature required if under 18 years old

WebIZ # ______________ **Patagonia #**______________ **Demo/Ins By:**__________ **IZ By:**_________ **Scanned By:**_________

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

COVID-19 Vaccine Screening Questionnaire 6 months to 17 years of age

1001 East 9th Street, Reno NV, 8951 **(ENGLISH)**

Complete the following for the minor patient receiving COVID-19 Vaccine:

Minor Patient Name: First________________________Middle______________________ Last____

Birth Date: _______/_______/________ Age: _______ Weight: ________ Sex: ☐ F ☐ M Ethnicity: Hispanic/Latino ☐ YES ☐ NO ☐ Not known

Race: (Check all that apply): ☐ White ☐ Black ☐ Asian ☐ Am Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Other/Mixed ☐ Unknown

Mailing Address: ______________________________City/State/Zip:____________________________ Email:__________________________________

Parent/Guardian Phone: (_____) -_________ - _________ Alternate Emergency Contact & phone ____

Parent/Guardian Consent:

I, ____, hereby attest as follows:

(Printed Name of Person Giving Consent)

1. **I am the (Check one): ☐ Parent ☐ Legal Guardian ☐ Other : __________________________________**
2. **I have the legal authority to make healthcare decisions on behalf of the minor patient named above.**
3. **I understand that I have the option to accept or refuse Pfizer-BioNTech COVID-19, Moderna COVID-19 or Novavax COVID-19 Vaccine on behalf of the minor patient.**
4. **I understand this vaccine is offered to all regardless of immigration status. Your information will not be shared.**
5. **I understand that the U.S. Food and Drug Administration ("FDA") has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine and Moderna COVID-19 vaccines for individuals aged 6 months and older.**
6. **The minor patient is between 6 months and 17 years of age.**
7. **I have been provided access to and read the Pfizer-BioNTech COVID-19 Vaccine Fact Sheet for Recipients and Caregivers ("Fact Sheet"), Moderna COVID-19 Vaccine EUA Fact Sheet for Recipients and Caregivers ("Fact Sheet"), or Novavax COVID-19 Vaccine Fact Sheet for Recipients and Caregivers ("Fact Sheet").**
8. **I understand there are potential risks and benefits of the Pfizer-BioNTech COVID-19, Moderna COVID-19 or Novavax COVID-19 Vaccine, the extent of which are known and unknown.**
9. **I understand that the Pfizer-BioNTech COVID-19 Vaccine, the Moderna COVID-19 Vaccine or the Novavax COVID-19 Vaccine consists of a two or three dose series, as well as may have recommended boosters.**
10. **I acknowledge I have had the opportunity to ask questions regarding the immunization to be administered to the minor patient.**
11. **The minor patient and I agree that he/she will remain in the observation area for the required time period following vaccine dose administration**
12. **Therefore, I hereby consent to the minor patient named above being administered the Pfizer-BioNTech COVID-19 Vaccine, Moderna COVID-19 Vaccine or the Novavax COVID-19 Vaccine. Further, I authorize all medically necessary treatment in the rare event that he/she has a reaction to the vaccine, including but not limited to itching, swelling, fainting, anaphylaxis, and other reactions**

Questions Regarding the Minor Patient:

Question	YES	NO
1. **Is the minor patient sick today? If yes, list symptoms:**____	☐	☐
2. **Have you received a dose of COVID-19 vaccine?** 3. If **YES**, which vaccine product did you receive? ☐ PFIZER ☐ MODERNA ☐ NOVAVAX ☐ Another product? _______________ HOW MANY DOSES?: #________ **DATE LAST DOSE** was received: ____/____/____ Did you bring your vaccination record card or other documentation? ☐ YES ☐ NO		
4. Does the minor have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies? ***This would include, but not be limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.***	☐	☐
5. **Has the minor patient had an allergic reaction to?** *(This would include a severe allergic reaction to [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 either of the following:**		
* Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparation for colonoscopy procedures?	☐	☐
* Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids?	☐	☐
A previous dose of COVID-19 vaccine?	☐	☐
Another vaccine (other than COVID-19 vaccine) or an injectable medication?	☐	☐

6. **Check all that apply to the minor patient:**

☐ A male between ages 12 and 39 years old
☐ Has a history of myocarditis or pericarditis
☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)
☐ Has a history of heparin-induced thrombocytopenia (HIT)
☐ Has a history of thrombosis with thrombocytopenia Syndrome (TTS)
☐ Has a history of Guillain-Barré Syndrome
☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum in the past 3 months?
☐ Vaccinated with monkeypox vaccine in the last 4 weeks
☐ Has ever fainted after receiving an injection

I hereby acknowledge that I have had the opportunity to ask questions regarding the immunization to be administered to the minor patient named above. I agree to allow his/her immunization information to be stored and accessed by authorized users in "Nevada's Web IZ". I also agree to have his/her blood tested for blood borne bacteria and viruses that may result in disease in the event person is exposed to his/her blood or body fluids. By signing this document, I declare that the above information is true and accurate to the best of my knowledge.

Signature: X ____ **Date:__________________**

Parent/Guardian signature required if under 18 years old

VACCINE	CVX	CPT	DATE GIVEN	LOT #	EXP. DATE	RT	SITE	DOSE	CLINIC	ADMINISTERED BY	FACT SHEET DATE
				PLACE STICKER HERE	LD RD	IM		____ mL	WCHD		12/2022 10/2022