Fax to: (402) 995-5665 **Version 1.3 - Updated 4/2/2021, 12:00 pm ET** Clear Data

2021 VHA SAVE LIVES ACT COVID-19 VACCINATION WORKSHEET

Name _____

Social Security # _____

Date of Birth _____

Address _____

City _____ **State** _____

Zip Code _____ **Phone** _____

Email _____

Birth Sex: ☐ Male ☐ Female

Gender: _____

Eligibility
- ☐ Non-Enrolled Veteran
- ☐ Spouse
- ☐ Caregiver
- ☐ Other: _____

For Spouse/Caregiver/Other Registration Only:
Veteran Name: _____

For Veteran Registration Only:
Branch of Service: _____
Date of Separation: _____
Total Time Active Duty: _____
Character of Discharge: _____

Race:
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Hawaiian/Pacific Islander
- ☐ Black/African American
- ☐ White
- ☐ Other
- ☐ Decline to Answer

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Medical Conditions:
- ☐ None
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Condition
- ☐ Liver Condition
- ☐ Kidney Condition
- ☐ Immunocompromised
- ☐ Pregnant
- ☐ Obesity
- ☐ Other _____

Pre-Vaccination Checklist

☐NO ☐YES 1. Are you feeling sick today?

☐NO ☐YES 2. Have you ever received a dose of COVID-19 vaccine?
- If no, will you be available to receive your 2nd dose? ☐NO ☐YES
- If yes, which vaccine product did you receive?
  ☐Pfizer ☐Moderna ☐Janssen (Johnson & Johnson) ☐Other _____

☐NO ☐YES 3. Have you ever had a severe allergic reaction (i.e., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital? To what? _____
- Was the severe allergic reaction after receiving a COVID-19 vaccine? ☐NO ☐YES

☐NO ☐YES 4. Have you received any vaccine in the last 14 days?

☐NO ☐YES 5. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?

☐NO ☐YES 6. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?

☐NO ☐YES 7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?

☐NO ☐YES 8. Do you have a bleeding disorder or are you taking a blood thinner?

☐NO ☐YES 9. Are you pregnant or breastfeeding?

☐NO ☐YES 10. Do you have dermal fillers?

I have read and fully understand the information regarding the COVID-19 vaccine and have been given the opportunity to ask questions. My signature below also acknowledges receipt and review of the VHA Notice of Privacy Practices, effective date September 30, 2019. I certify the information I provided is true and correct. I understand that it's a crime to give false information. Penalties may include a fine, imprisonment or both.

Date _____ **Signature** _____

To be Completed by Vaccinator/Healthcare Provider

☐ *Emergency Use Authorization (EUA) Reviewed/Provided*

Date: _____

Site: ☐Left Deltoid ☐Right Deltoid

Vaccine: ☐Pfizer ☐Moderna ☐Janssen (J&J)

Expiration Date: _____

Lot No.: _____

☐ *Charted in CPRS* **Vaccine Administrator:** _____