County of San Bernardino
SARS CoV-2 (COVID-19) Vaccine
Employee and Community Information Form

SARS CoV-2 VACCINE FORM

Last Name (Print): _____ **First Name:** _____ **Date of Birth:** _____ **Age:** _____

Address: City: _____ **Zip Code:** _____ **Phone Number:** _____

Mother's First Name _____ **Email:**_____

Gender:
☐ Male ☐ Female
☐ Nonbinary
☐ Decline to Answer

Race:
☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Decline to Answer
☐ Unknown ☐ White ☐ Other_____

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline to Answer

SECTION I: SARS CoV-2 VACCINE INFORMATION

- You are being offered the COVID-19 Vaccine to prevent Coronavirus disease 2019 (COVID-19). FDA has authorized the emergency use of this vaccine. The Fact Sheet provided contains information to help you understand risks and benefits of receiving this vaccine.
- The COVID-19 vaccine does not contain SARS CoV-2 and it will not give you COVID-19 infection.
- The Pfizer-BioNTech vaccine is a 2-dose series given 3 weeks apart into the deltoid muscle. The Moderna vaccine requires 2-doses 28 days apart. The vaccine series should be completed using the same type of COVID Vaccine. The Janssen vaccine is a single dose vaccine.
- The SARS CoV 2 vaccine is offered **free of cost** through County of San Bernardino.

SECTION II: COMPLETE IF RECEIVING VACCINE (You may be referred to your personal physician with any YES answers.)

Please answer the following questions by checking "YES" or "NO"

1. Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headaches, new loss of taste loss of taste or smell, sore throat, nausea, vomiting, or diarrhea within the past 10 days? (if yes, circle those that apply)	☐YES ☐ NO
2. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to another vaccine or injectable medication?	☐YES ☐ NO
3. Have you ever had a severe allergic reaction to anything for which you were treated with epinephrine, EpiPen, or had to go to the hospital?	☐YES ☐ NO
4. In the past 10 days, have you tested positive for COVID-19 infection or are you currently being monitored for COVID -19 infection (e.g. in quarantine)?	☐YES ☐ NO
5. In the past 90 days, have you received convalescent plasma or monoclonal antibody infusion as part of COVID-19 infection treatment?	☐YES ☐ NO
6. **For Females**: Are you currently pregnant, will become pregnant within the next 4 weeks, breast feeding or lactating? ☐ N/A	☐YES ☐ NO

☐ **Check if person receiving vaccine is under 18 years of age.** **Name of Parent/Guardian**_____

I have been given the vaccine Fact Sheet and have and I have had the opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of SARS CoV-2 Vaccine and that it is being offered pursuant to an Emergency Use Authorization as indicated in 21 U.S.C. 360bbb-3(e)(1)(A)ii)(III). I release County of San Bernardino, its employees and representatives from any liability or further responsibility with regard to my receiving the vaccine. I understand that regardless of receiving SARS CoV-2 vaccine, universal source control measures, including the use of a face mask, social distancing, and recommendations from federal, state, and local authorities remain in effect until instructed otherwise.

Signature: _____ **Date:** _____

SECTION III: FOR OFFICE USE ONLY – SARS CoV-2 Vaccination Record

Vaccine: Covid-19 Vaccine ☐ Dose #1 ☐ Dose #2	Vaccine Date Administered:
Manufacturer:	Dose: _____ mL Route: Intramuscular (IM)
Lot#:	Site: ☐ Left Deltoid ☐ Right Deltoid
Expiration Date:	Vaccine Administered by:
EUA Fact Sheet or VIS Given: ☐ YES ☐ NO	
VIS Date: *(Currently under EUA status)*	Title: ☐ RN ☐ LVN ☐ Pharmacist ☐ _____
2nd Dose appointment Day Time	