South Dakota State University
Student Health Clinic and Counseling Services
COVID-19 Immunization Screening and Consent Form

Full Legal Name:			
Date of Birth:	Legal Gender: Male Female __________ Other____________		
South Dakota Address:	City:	Zip	Phone:

Ethnicity	Race	
Cuban Mexican Non-Hispanic Puerto Rican Unknown Other ________________	Asian Indian Black Chinese Korean	Native American Pacific Islander Unknown White
	Other:	

	Screening Questionnaire	Yes	No	Unknown
1	Are you feeling sick today?			
2	In the last 10 days, have you had a positive COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?			
3	Have you been treated with **antibody infusion therapy** for COVID-19 infection in the past 90 days? ***If yes, when did you receive the last dose:*** ____________			
4	Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot?			
5	Have you had any vaccines in the past 14 days (2 weeks) including the flu shot? *If yes,* ***how long ago was you most recent vaccine****:* ______________			
6	Have you had a **previous Covid-19 vaccine** (Pfizer, Moderna, or Janssen/J & J) or others outside the U.S.? ; **If yes; list dates**___________________________________			
7	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?			
8	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, tumor necrosis factors drugs (i.e. Humira), allergy injections, Xolair, or have you had any radiation treatments?			
9	Do you have a medical history of any blood disorders (including low platelets/ thrombocytopenia or blood clots/thrombosis?			
YES	By signing this form, I would like the COVID-19 vaccine given to myself. I have been provided with the opportunity to read the "COVID-19 Vaccine Fact Sheet for Recipients" and understand potential health risks and warning symptoms.			

Patient Signature: ____ Date: _________________________________

For Vaccinator Use Only				
Vaccine Manufacturer: Lot #: Expiration Date:				Administered By: Administration Date:
Time of Administration:			Time of Departure:	
Site of Administration:	Deltoid	Left	Right	