**Office Only**

**ASIIS #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_

 Male □ Female □ Date of Birth: Month \_\_\_\_\_\_\_\_\_\_\_\_ Day \_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_

Race: □White □Asian □Black or African American □Hispanic □American Indian or Alaska Native □Native Hawaiian or Other Pacific Islander □Other

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino

Insured for vaccines? No □ Yes □ Name of Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID/SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For patients to be vaccinated**

The following questions will help us determine if there is any reason, we should not give you the Janssen COVID-19 Vaccine today. If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Do you have a history of severe allergic reaction to any component of the vaccine, recombinant, replication-incompetent adenovirus type 26 expressing the SARS-CoV-2 spike protein, citric acid monohydrate, trisodium citrate dihydrate, ethanol, 2-hydroxypropyl-β-cyclodextrin (HBCD), polysorbate-80, sodium chloride.

 Yes □ No □

 If yes divert or alternately route to a physician consult.

1. Do you have a history of severe allergic reaction to another vaccine or injectable medication?

Yes □ No □

 If yes recommended to observe for 30 minutes

3. If you have an immunocompromised condition, are pregnant or breastfeeding have you had the opportunity to discuss the decision to vaccinate with your healthcare provider and/or are you ready to proceed with vaccination? Yes □ No □

 If Yes, proceed with vaccination.

 If no, provide immunosuppression, pregnancy, lactation fact sheet and pull out of the line to determine whether they would like to be vaccinated at this visit.

□ **I have been given a copy of the FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) OF THE JANSEEN COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 18 YEARS OF AGE AND OLDER.**

**Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Staff Only:****Vaccine Administration:**  Janssen Covid-19 vaccine **□** Site:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Vaccine label or lot number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date\_\_\_\_\_\_\_\_\_\_ NDC number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |