Health, Housing & Human Services
CLACKAMAS COUNTY

PUBLIC HEALTH VACCINE SCREENING QUESTIONNAIRE

Clackamas County Public Health Immunizations
2051 Kaen Rd, Suite 367
Oregon City, OR 97045
Clinic site: _____

Patient Name, Last:_____ First: _____ Middle: _____

Preferred Name: _____ Pronouns:_____

Date of Birth: _____ Age: _____ Gender: ❑ Male ❑ Female ❑ Other ❑ Decline to answer

❑Home *or* ❑ Mailing- Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Email address (for 2nd appointment): _____Language preference: _____

Patient race: (Check all that apply) ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/ African American
❑ Native Hawaiian/ Pacific Islander ❑ White ❑ Other ❑ Decline to answer

A. GENERAL Vaccine Screening Questions	**Circle one:**		
1. Do you have a fever or feel sick today?	Yes	No	
2. In the last 10 days, have you tested positive for COVID-19 (either at home, testing center, or at a medical provider)?	Yes	No	
3. Have you ever had a severe allergic reaction (i.e. Anaphylaxis or hives/swelling/difficulty breathing) to something that required treatment with epinephrine or EpiPen®, or for which you had to go to the hospital? This includes another vaccine, injectable or oral medication, food, pet, bee sting, etc…?	Yes	No	Unknown
4. Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	Yes	No	Unknown
5. Are you moderately to severely immunocompromised? (i.e. Chemotherapy, organ transplant, immunosuppressive drugs, high-dose corticosteroids, HIV infection)	Yes	No	Unknown
6. Have you ever fainted after an injection or blood draw?	Yes	No	

B. COVID-19 Vaccine Screening Questions	**Circle one:**		
1. Have you ever received a dose of COVID-19 vaccine? • **If yes**, which: ❑Pfizer ❑Moderna ❑Novavax ❑Janssen/J&J ❑Other:_____ • **If yes**, was your last dose: ❑Primary dose *or* ❑Booster dose	Yes	No	Unknown
2. Have you ever had an immediate allergic reaction or anaphylaxis to any of the following: • A previous dose of the COVID-19 vaccine, or any ingredients of the vaccine? • Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures? • Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids?	 Yes Yes Yes	 No No No	 Unknown Unknown Unknown

C. FLU Vaccine Screening Questions	**Circle one:**		
1. Do you have health insurance? • **If yes,** is it: ❑ Private (*employer provided, family/spouse provided, or otherwise paid for privately*) ❑ OHP/Medicaid *(Provided for **free** by the state of Oregon, i.e. Health Share, Trillium, PacificSource)*	Yes	No	Unknown
2. Is today's flu shot your first flu vaccine ever? *(For under 8 years old only. If yes, schedule booster dose after 28 days)*	Yes	No	Unknown
3. Have you ever had Guillain-Barré Syndrome within 6 weeks after receiving a flu vaccine?	Yes	No	Unknown
4. Do you have a severe allergy to eggs? *(2022-2023 fly year: If yes, administer Flucelvax)*	Yes	No	Unknown
5. Are you pregnant, planning to become pregnant, or breastfeeding?	Yes	No	Unknown

D. JYNNEOS Vaccine Screening Questions	Circle one:		
1. Are you 15 years of age or older?	Yes	No	Unknown
2. Do you have swollen lymph nodes, a rash, skin blisters or lesions?	Yes	No	Unknown
3. Have you ever had an immediate allergic reaction or anaphylaxis to a previous dose of JYNNEOS?	Yes	No	Unknown
4. Have you ever had an immediate allergic reaction or anaphylaxis to any ingredients of JYNNEOS™, including Gentamicin, Ciprofloxacin, Benzonase or egg protein?	Yes	No	Unknown
5. Have you ever had Stephen-Johnson syndrome (SJS) or Toxic Epidermal Necrolysis (TEN) following either ciprofloxacin or gentamicin?	Yes	No	Unknown
6. Do you have a history of developing keloid scars?	Yes	No	Unknown

Patient/Legal Guardian Consent

I have received, read and had my questions answered about the Emergency Use Authorization/Vaccine Information Fact Sheet. I understand the risks and benefits involved in receiving this vaccine. I consent to the vaccine being given to me or the person named above for whom I have the legal authority to consent. I consent to the release of any information needed to process insurance claims and/or request payments of medical benefits.

Print name: _____

Signature: _____

Date: _____

If not patient, relationship to patient: _____

If signing on behalf of a minor 14 years of age or younger receiving an influenza or COVID-19 vaccine, please read and initial below:

_____ I have the legal authority to consent on behalf of the child/minor named above to vaccination.

_____ I attest that the person receiving the vaccine is six months of age or older, and that the birthdate and age stated above are correct.

_____ I understand that I am not required to accompany the child/minor named above to their vaccination appointment and that, by giving my consent; the child/minor will receive an influenza, Pfizer, Moderna or Novavax vaccine whether or not I am present at the vaccination appointment. If I am not present, an adult over 18 will accompany my child.