

**Plumas County Public Health Agency**  
**COVID-19 Vaccination Screening Form**

Please mark the answer to the following questions for the person who is receiving the COVID-19 vaccine.

**Please Print**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Gender:  Male

Female

Zip Code: \_\_\_\_\_

Town/City: \_\_\_\_\_

E-mail: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Race:  Native American  Black  Hispanic/ Latino  White  Other:

First Dose  Second Dose

1. Are you pregnant or think you might be?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
2. Are you feeling sick today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
3. Previous severe allergic reaction (e.g. anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to hospital.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
3a. Was the allergic reaction after receiving a COVID-19 vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
3b. Was the severe reaction after receiving another vaccination or other injectable medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
4. Have you ever had a positive test for COVID-19?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
5. Have you received passive antibody treatment for COVID-19? If yes, date of treatment:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
6. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know

Your vaccination will be entered into our immunization database for inventory tracking and public health surveillance purposes.

Please read the HIPPA Privacy Statement as well as the uses and disclosures for Public Health Activities available on the back of this form.

Parent/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Parent/Guardian Name: \_\_\_\_\_

Pfizer <input type="checkbox"/>	Moderna <input type="checkbox"/>	<input type="checkbox"/> Janssen	Other <input type="checkbox"/>
Clinic Date: _____	Arm Injected: <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm		
Nurse: _____	Lot #:	_____	

*Contact Plumas County Public Health Agency (530) 283-6330 for questions.*



***HIPAA Privacy Statement***  
***The complete definition of Protected Health Information (PHI)***

Any individually identifiable health information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual. Any data transmitted or maintained in any other form or medium by covered entities, **including paper records, fax documents and all oral communications**, or any other form, i.e., screen prints of eligibility information, printed e-mails that have identified individual's health information, claim, or billing information, hard copy birth or death certificate.

**Protected health information excludes:** school records that are subject to the Family Educational Rights and Privacy Act; and employment records held in the County's role as an employer.

**Uses and Disclosures for Public Health Activities**

According to the Health and Safety Code Part II 45 CFR 164.501 Plumas County Public Health Department is a covered entity which may disclose protected health information for certain specified public health activities which may be, but not limited to:

- Disease prevention and control, including reporting
- Vital records reporting
- Public Health surveillance
- Legally authorized disclosure of protected health information to a person or persons who may be at risk of contracting or spreading a reportable disease
- Certain providers hired by employers may provide information to the employer related to workplace medical surveillance or work-related illness or injury
- Reporting under Food and Drug Administration requirements for adverse events or problems related to certain regulated projects