



# Minors Receiving COVID-19 Vaccine: Parental Checklist



**START**



When a person age 12-17 wishes to receive the Pfizer COVID-19 vaccine...



**Parent must:**

- Read the **Pfizer EUA Factsheet**
- Read the **Notice of Privacy Practices**
- Complete the **Vaccine Screening Form** and bring it to vaccine event.



**If a parent/guardian **can** attend vaccination event with their minor child:**

Please bring the screening form and proof of your child's age with you to the vaccine event.

**If a parent/guardian **can not** attend vaccination event with their minor child:**



**Parent **must also**:**

- Give consent for their child to receive the vaccine by phone call or video call.
- An on-site witness must sign bottom portion of Vaccine Screening Form attesting to parent's verbal permission.

## **FACT SHEET FOR RECIPIENTS AND CAREGIVERS**

### **EMERGENCY USE AUTHORIZATION (EUA) OF THE PFIZER-BIONTECH COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 12 YEARS OF AGE AND OLDER**

You are being offered the Pfizer-BioNTech COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2. This Fact Sheet contains information to help you understand the risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine, which you may receive because there is currently a pandemic of COVID-19.

The Pfizer-BioNTech COVID-19 Vaccine is a vaccine and may prevent you from getting COVID-19. There is no U.S. Food and Drug Administration (FDA) approved vaccine to prevent COVID-19.

Read this Fact Sheet for information about the Pfizer-BioNTech COVID-19 Vaccine. Talk to the vaccination provider if you have questions. It is your choice to receive the Pfizer-BioNTech COVID-19 Vaccine.

The Pfizer-BioNTech COVID-19 Vaccine is administered as a 2-dose series, 3 weeks apart, into the muscle.

The Pfizer-BioNTech COVID-19 Vaccine may not protect everyone.

This Fact Sheet may have been updated. For the most recent Fact Sheet, please see [www.cvdvaccine.com](http://www.cvdvaccine.com).

## **WHAT YOU NEED TO KNOW BEFORE YOU GET THIS VACCINE**

### **WHAT IS COVID-19?**

COVID-19 disease is caused by a coronavirus called SARS-CoV-2. This type of coronavirus has not been seen before. You can get COVID-19 through contact with another person who has the virus. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness. Symptoms may appear 2 to 14 days after exposure to the virus. Symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

### **WHAT IS THE PFIZER-BIONTECH COVID-19 VACCINE?**

The Pfizer-BioNTech COVID-19 Vaccine is an unapproved vaccine that may prevent COVID-19. There is no FDA-approved vaccine to prevent COVID-19.

The FDA has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine to prevent COVID-19 in individuals 12 years of age and older under an Emergency Use Authorization (EUA).

For more information on EUA, see the “**What is an Emergency Use Authorization (EUA)?**” section at the end of this Fact Sheet.

### **WHAT SHOULD YOU MENTION TO YOUR VACCINATION PROVIDER BEFORE YOU GET THE PFIZER-BIONTECH COVID-19 VACCINE?**

**Tell the vaccination provider about all of your medical conditions, including if you:**

- have any allergies
- have a fever
- have a bleeding disorder or are on a blood thinner
- are immunocompromised or are on a medicine that affects your immune system
- are pregnant or plan to become pregnant
- are breastfeeding
- have received another COVID-19 vaccine
- have ever fainted in association with an injection

### **WHO SHOULD GET THE PFIZER-BIONTECH COVID-19 VACCINE?**

FDA has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine in individuals 12 years of age and older.

### **WHO SHOULD NOT GET THE PFIZER-BIONTECH COVID-19 VACCINE?**

You should not get the Pfizer-BioNTech COVID-19 Vaccine if you:

- had a severe allergic reaction after a previous dose of this vaccine
- had a severe allergic reaction to any ingredient of this vaccine.

### **WHAT ARE THE INGREDIENTS IN THE PFIZER-BIONTECH COVID-19 VACCINE?**

The Pfizer-BioNTech COVID-19 Vaccine includes the following ingredients: mRNA, lipids ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-Distearoyl-sn-glycero-3-phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose.

### **HOW IS THE PFIZER-BIONTECH COVID-19 VACCINE GIVEN?**

The Pfizer-BioNTech COVID-19 Vaccine will be given to you as an injection into the muscle.

The Pfizer-BioNTech COVID-19 Vaccine vaccination series is 2 doses given 3 weeks apart.

If you receive one dose of the Pfizer-BioNTech COVID-19 Vaccine, you should receive a second dose of this same vaccine 3 weeks later to complete the vaccination series.

### **HAS THE PFIZER-BIONTECH COVID-19 VACCINE BEEN USED BEFORE?**

The Pfizer-BioNTech COVID-19 Vaccine is an unapproved vaccine. In clinical trials, approximately 23,000 individuals 12 years of age and older have received at least 1 dose of the Pfizer-BioNTech COVID-19 Vaccine.

### **WHAT ARE THE BENEFITS OF THE PFIZER-BIONTECH COVID-19 VACCINE?**

In an ongoing clinical trial, the Pfizer-BioNTech COVID-19 Vaccine has been shown to prevent COVID-19 following 2 doses given 3 weeks apart. The duration of protection against COVID-19 is currently unknown.

### **WHAT ARE THE RISKS OF THE PFIZER-BIONTECH COVID-19 VACCINE?**

There is a remote chance that the Pfizer-BioNTech COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the Pfizer-BioNTech COVID-19 Vaccine. For this reason, your vaccination provider may ask you to stay at the place where you received your vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include:

- Difficulty breathing
- Swelling of your face and throat
- A fast heartbeat
- A bad rash all over your body
- Dizziness and weakness

Side effects that have been reported with the Pfizer-BioNTech COVID-19 Vaccine include:

- severe allergic reactions
- non-severe allergic reactions such as rash, itching, hives, or swelling of the face
- injection site pain
- tiredness
- headache
- muscle pain
- chills
- joint pain
- fever
- injection site swelling
- injection site redness
- nausea
- feeling unwell
- swollen lymph nodes (lymphadenopathy)
- diarrhea
- vomiting
- arm pain

These may not be all the possible side effects of the Pfizer-BioNTech COVID-19 Vaccine. Serious and unexpected side effects may occur. Pfizer-BioNTech COVID-19 Vaccine is still being studied in clinical trials.

## **WHAT SHOULD I DO ABOUT SIDE EFFECTS?**

If you experience a severe allergic reaction, call 9-1-1, or go to the nearest hospital.

Call the vaccination provider or your healthcare provider if you have any side effects that bother you or do not go away.

Report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS). The VAERS toll-free number is 1-800-822-7967 or report online to <https://vaers.hhs.gov/reportevent.html>. Please include "Pfizer-BioNTech COVID-19 Vaccine EUA" in the first line of box #18 of the report form.

In addition, you can report side effects to Pfizer Inc. at the contact information provided below.

<b>Website</b>	<b>Fax number</b>	<b>Telephone number</b>
<a href="http://www.pfizersafetyreporting.com">www.pfizersafetyreporting.com</a>	1-866-635-8337	1-800-438-1985

You may also be given an option to enroll in v-safe. V-safe is a new voluntary smartphone-based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after COVID-19 vaccination. V-safe asks questions that help CDC monitor the safety of COVID-19 vaccines. V-safe also provides second-dose reminders if needed and live telephone follow-up by CDC if participants report a significant health impact following COVID-19 vaccination. For more information on how to sign up, visit: [www.cdc.gov/vsafe](http://www.cdc.gov/vsafe).

## **WHAT IF I DECIDE NOT TO GET THE PFIZER-BIONTECH COVID-19 VACCINE?**

It is your choice to receive or not receive the Pfizer-BioNTech COVID-19 Vaccine. Should you decide not to receive it, it will not change your standard medical care.

## **ARE OTHER CHOICES AVAILABLE FOR PREVENTING COVID-19 BESIDES PFIZER-BIONTECH COVID-19 VACCINE?**

Currently, there is no approved alternative vaccine available for prevention of COVID-19. Other vaccines to prevent COVID-19 may be available under Emergency Use Authorization.

## **CAN I RECEIVE THE PFIZER-BIONTECH COVID-19 VACCINE WITH OTHER VACCINES?**

There is no information on the use of the Pfizer-BioNTech COVID-19 Vaccine with other vaccines.

## **WHAT IF I AM PREGNANT OR BREASTFEEDING?**

If you are pregnant or breastfeeding, discuss your options with your healthcare provider.

## **WILL THE PFIZER-BIONTECH COVID-19 VACCINE GIVE ME COVID-19?**

No. The Pfizer-BioNTech COVID-19 Vaccine does not contain SARS-CoV-2 and cannot give you COVID-19.


## **KEEP YOUR VACCINATION CARD**

When you get your first dose, you will get a vaccination card to show you when to return for your second dose of Pfizer-BioNTech COVID-19 Vaccine. Remember to bring your card when you return.

## **ADDITIONAL INFORMATION**

If you have questions, visit the website or call the telephone number provided below.

To access the most recent Fact Sheets, please scan the QR code provided below.

<b>Global website</b>	<b>Telephone number</b>
<p><a href="http://www.cvdvaccine.com">www.cvdvaccine.com</a></p> 	<p>1-877-829-2619 (1-877-VAX-CO19)</p>

## **HOW CAN I LEARN MORE?**

- Ask the vaccination provider.
- Visit CDC at <https://www.cdc.gov/coronavirus/2019-ncov/index.html>.
- Visit FDA at <https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization>.
- Contact your local or state public health department.

## **WHERE WILL MY VACCINATION INFORMATION BE RECORDED?**

The vaccination provider may include your vaccination information in your state/local jurisdiction's Immunization Information System (IIS) or other designated system. This will ensure that you receive the same vaccine when you return for the second dose. For more information about IISs visit: <https://www.cdc.gov/vaccines/programs/iis/about.html>.

## **CAN I BE CHARGED AN ADMINISTRATION FEE FOR RECEIPT OF THE COVID-19 VACCINE?**

No. At this time, the provider cannot charge you for a vaccine dose and you cannot be charged an out-of-pocket vaccine administration fee or any other fee if only receiving a COVID-19 vaccination. However, vaccination providers may seek appropriate reimbursement from a program or plan that covers COVID-19 vaccine administration fees for the vaccine recipient (private insurance, Medicare, Medicaid, Health Resources & Services Administration [HRSA] COVID-19 Uninsured Program for non-insured recipients).

### **WHERE CAN I REPORT CASES OF SUSPECTED FRAUD?**

Individuals becoming aware of any potential violations of the CDC COVID-19 Vaccination Program requirements are encouraged to report them to the Office of the Inspector General, U.S. Department of Health and Human Services, at 1-800-HHS-TIPS or <https://TIPS.HHS.GOV>.

### **WHAT IS THE COUNTERMEASURES INJURY COMPENSATION PROGRAM?**

The Countermeasures Injury Compensation Program (CICP) is a federal program that may help pay for costs of medical care and other specific expenses of certain people who have been seriously injured by certain medicines or vaccines, including this vaccine. Generally, a claim must be submitted to the CICP within one (1) year from the date of receiving the vaccine. To learn more about this program, visit [www.hrsa.gov/cicp/](http://www.hrsa.gov/cicp/) or call 1-855-266-2427.

### **WHAT IS AN EMERGENCY USE AUTHORIZATION (EUA)?**

The United States FDA has made the Pfizer-BioNTech COVID-19 Vaccine available under an emergency access mechanism called an EUA. The EUA is supported by a Secretary of Health and Human Services (HHS) declaration that circumstances exist to justify the emergency use of drugs and biological products during the COVID-19 pandemic.

The Pfizer-BioNTech COVID-19 Vaccine has not undergone the same type of review as an FDA-approved or cleared product. FDA may issue an EUA when certain criteria are met, which includes that there are no adequate, approved, available alternatives. In addition, the FDA decision is based on the totality of scientific evidence available showing that the product may be effective to prevent COVID-19 during the COVID-19 pandemic and that the known and potential benefits of the product outweigh the known and potential risks of the product. All of these criteria must be met to allow for the product to be used in the treatment of patients during the COVID-19 pandemic.

The EUA for the Pfizer-BioNTech COVID-19 Vaccine is in effect for the duration of the COVID-19 EUA declaration justifying emergency use of these products, unless terminated or revoked (after which the products may no longer be used).



Manufactured by  
Pfizer Inc., New York, NY 10017

**BIONTECH**

Manufactured for  
BioNTech Manufacturing GmbH  
An der Goldgrube 12  
55131 Mainz, Germany

LAB-1451-4.2a  
Revised: 10 May 2021



Scan to capture that this Fact Sheet was provided to vaccine recipient for the electronic medical records/immunization information systems.

Barcode Date: 05/2021





## San Luis Obispo County Health Agency

### Notice of Privacy Practices

Effective January 18, 2019

# Your Information. Your Rights. Our Responsibilities.

This describes how medical information about you may be used and disclosed and how you can get access to this information.

**Please review it carefully.**

## Your Rights

**When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.**

### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you, including results of lab tests performed by us. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- You may submit your request in writing at any clinic or by writing to:  
*SLO County Medical Records  
2178 Johnson Avenue  
San Luis Obispo, CA. 93401*
- If you have questions about the process you may call (805) 781-4724.

### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

## **Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

## **Get a copy of this privacy notice**

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

## **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

## **File a complaint if you feel your rights are violated**

You can complain if you feel we have violated your rights by contacting us in the following ways:

- You can call the toll-free confidential hotline at: **(855) 326-9623**
- Or you can contact us by e-mail at: [privacy@co.slo.ca.us](mailto:privacy@co.slo.ca.us)
- Or send a letter to: Privacy Officer  
San Luis Obispo County Health Agency  
2180 Johnson Avenue  
San Luis Obispo, CA 93401
- Contact Department of Health & Human Services at: Office of Civil Rights  
90 7th Street, Suite 4-100  
San Francisco, CA 94103
- Or you can file a complaint online at: [www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints)
- Or call toll free at: (800) 368-1019 - TDD (800) 537-7697

**You will not be punished or penalized for asking questions or for filing a complaint.**

## **Your Choices**

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**For certain health information, you can tell us your choices about what we share.** If you have a preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

**Note:** This section lists several of the ways in which healthcare providers may share your information; however, many do not apply to the practices of the San Luis Obispo County Health Agency.

**In these cases, you have both the right and choice to tell us to:**

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a directory (the Health Agency doesn't use a patient directory)

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

**In these cases we never share your information unless you give us written permission:**

- Marketing purposes (The Health Agency does not use your information for marketing.)
- Sale of your information (the Health Agency does not sell your information)
- Most sharing of psychotherapy notes

**In the case of fundraising**

- The Health Agency will not contact you for any fundraising effort.

## **Our Uses and Disclosures**

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**We typically use or share your health information in the following ways.**

**Treat you**

- We can use your health information and share it with other professionals who are treating you. (Exceptions exist for substance use treatment – see below)
  - *Example:* A doctor sends us information about your diagnosis and treatment plan so that we can arrange additional services

**Run our organization**

- We can use and share your health information to run our organization, improve your care, and contact you when necessary.
  - *Example:* We use health information about you to manage your treatment and services.

**Bill for your services**

- We can use and share your health information to bill and get payment from health plans or other entities.
  - *Example:* We give information about you to your health insurance plan so that it will pay for your services.

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

(Note: This Notice will separately describe the ways that the County can use or disclose HIV/AIDS results and substance use disorder treatment records subject to 42 CFR Part 2)

**Health Information Exchange (HIE):**

The County of San Luis Obispo participates in a HIE. Through this system, we may disclose your health information for purposes of coordinating your care between healthcare providers, and other purposes allowed under the law. Sharing your health information can be done electronically through the HIE and can provide faster access, better coordination of care, and assist healthcare providers and public health officials in making informed decisions. You will need to opt-out of the HIE system if you DO NOT wish to have San Luis Obispo County Health Agency share your information through the HIE, otherwise your information will automatically

be included with some exceptions. Mental Health, Substance Use Disorder, HIV and STD information will NOT be included in the HIE.

If at any time you want to opt-out of the HIE or opt back in to the HIE, you may do so online at: <http://www.ocprhio.org/Patients/optout/>.

### **Help with public health and safety issues.**

We can share health information about you for situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to health or safety

### **Do research**

- We can use or share your information for health research.

### **Comply with the law**

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

### **Respond to organ and tissue donation requests**

- We can share health information about you with organ procurement organizations.

### **Work with a medical examiner or funeral director**

- We can share health information with a coroner, medical examiner, or funeral director if an individual dies.

### **Address workers' compensation, law enforcement, and other government requests.**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes and officials
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### **Respond to lawsuits and legal actions**

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

### **For Clients of Substance Use Disorder Treatment Programs (42CFR 2.22 Notice):**

Federal Law and regulations protect the confidentiality of substance use disorder treatment patient records. Generally, the program may not say that you attend the program or disclose any information identifying you as having a substance use disorder.

Federal law allows us to share your substance use disorder information for the following reasons:

- If you (or your authorized representative), consents in writing.
- The disclosure is allowed by a court order.
- The disclosure is made to medical personnel in a medical emergency.
- The disclosure is made to qualified personnel for research, audit, or program evaluation.

- The disclosure is made pursuant to an agreement with a qualified service organization.
- If you commit a crime on our premises or against our personnel.
- If we need to report suspected child abuse or any other report that is required by law.

You may get more information by seeing federal law 42CFR Part 2. Violation of these laws is a crime and suspected violations may be reported to the following agencies:

SAMHSA - 5600 Fishers Lane, Rockville, MD. 20857 or [www.samhsa.gov/about-us/contact-us](http://www.samhsa.gov/about-us/contact-us)

U.S Attorney, Central District - 312 N. Spring St, #1200, Los Angeles, CA. 90012 or [www.justice.gov/usao-cdca/contact](http://www.justice.gov/usao-cdca/contact)

### **Uses and Disclosures of HIV/AIDS Information:**

In general, written authorization (by client or authorized representative) is required for the disclosure of HIV/AIDS test results. The following exceptions apply:

- Disclosures made to your health care provider for purposes of diagnosis, treatment, or care.
- State reporting requirements for Public Health purposes.
- Payment: to bill for the cost of your healthcare (for example, to bill Medi-Cal or Medicare).
- Operations: we may use or disclose your information to support our business operations (for example, to evaluate staff performance or review the quality of services provided to you).
- Other disclosures that may be required under the law.

### **Violation of the Federal law and regulations by a program is a crime.**

Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

## **Our Responsibilities**

- we are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For information about our responsibilities for this notice, see:

**[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).**

**This notice applies to the following services within the San Luis Obispo County Health Agency:**

- **Mental Health Services – See:** [www.slocounty.ca.gov/health/mentalhealthservices](http://www.slocounty.ca.gov/health/mentalhealthservices)
- **Drug & Alcohol Services – See:** [www.slocounty.ca.gov/health/DAS\\_Home](http://www.slocounty.ca.gov/health/DAS_Home)
- **Public Health Services – See:** [www.slocounty.ca.gov/health/publichealth](http://www.slocounty.ca.gov/health/publichealth)

You may ask about Health Agency programs and clinic locations by calling 805-781-5500.

*Health information about services you may have received from our Mental Health or Drug and Alcohol programs is filed in an electronic health records system that is shared between the two programs. Staff members of these two programs are allowed limited access to your health information and only the minimum amount necessary to provide for your treatment, to receive payment for services, and to run the operations of our organization.*

**Changes to the Terms of this Notice**

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

**For questions about this notice:**

- Contact the Health Agency Compliance Program Manager at: 805-781-4788.
- Or send an e-mail to: [privacy@co.slo.ca.us](mailto:privacy@co.slo.ca.us)
- Or send a letter to:  
County of SLO Health Agency  
Compliance Program Manager  
2180 Johnson Ave., San Luis Obispo, CA. 93401

## Discrimination is Against the Law

San Luis Obispo County complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The County does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. San Luis Obispo County:

- A. Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters;
- B. Written information in other formats;
- C. Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, please contact the Health Agency at (800) 838-1381

If you believe that the County has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **Patient Rights Advocate**

**2180 Johnson Avenue, San Luis Obispo, CA. 93401**  
**(805) 781-4738, <mailto:BH.PatientRightsAdvocate@co.slo.ca.us>**

Español (Spanish)	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 838-1381
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 838-1381
Tiếng Việt (Vietnamese)	CHU Y: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 838-1381
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 838-1381
Tagalog (Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 838-1381
Հայերեն (Armenian)	Ուշադրություն: Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվակախան աջակցություններ: Չանգահարեք (800) 838-1381
فارسی (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما (800) 838-1381
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 838-1381
日本語 (Japanese)	注意事項：日本語を話される場合、無料の言語支援をご利用いただけません。(800)838-1381
العربية (Arabic)	رقم (800) 838-1381 - ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان اتصل برقم
ខ្មែរ (Cambodian)	ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតល្អូល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ (800) 838-1381 ។
Hmoob (Hmong)	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 838-1381
ਪੰਜਾਬੀ (Punjabi)	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਨੂੰ ਮੁਫਤ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (800) 838-1381
हिंदी (Hindi)	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (800)838-1381
ภาษาไทย (Thai)	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (800) 838-1381
ພາສາລາວ (Lao)	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ (800) 838-1381

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Patient Rights Advocate is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>.



# COVID-19 VACCINE SCREENING FORM

County of San Luis Obispo Public Health Department

2191 Johnson Ave, San Luis Obispo, CA 93401

Phone: 805-781-5500 | Fax: 805-781-5543 | www.slopublichealth.org

2021-2022

DEMOGRAPHIC INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Street Address: \_\_\_\_\_ Mother's First Name: \_\_\_\_\_

City: \_\_\_\_\_ ZIP: \_\_\_\_\_ Gender: Male Female Decline to state

<b>RACE (select 1):</b>	American Indian or Alaska Native	Asian	Native Hawaiian/Pacific Islander
	Black or African-American	White	Other (fill in below): _____

Phone (xxx-xxx-xxxx): \_\_\_\_\_ Birthdate (mm/dd/yyyy): \_\_\_\_\_ Email: \_\_\_\_\_

**Ethnicity (select 1):** **HISPANIC OR LATINO** **NOT HISPANIC OR LATINO**

HEALTH HISTORY INFORMATION

1. Are you feeling sick today? YES NO DON'T KNOW

2. Have you ever received a dose of COVID-19 vaccine? YES NO DON'T KNOW  
• If yes, which vaccine product did you receive?  
 Pfizer  Moderna  Janssen (Johnson & Johnson)  Another Product \_\_\_\_\_  
• Did you bring your vaccination record card or other documentation? (yes/no) YES NO DON'T KNOW

3. Have you ever had an allergic reaction to: YES NO DON'T KNOW  
*(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*  
• A component of a COVID-19 vaccine, including either of the following:  
○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures YES NO DON'T KNOW  
    
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids YES NO DON'T KNOW

• A previous dose of COVID-19 vaccine YES NO DON'T KNOW

4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? YES NO DON'T KNOW  
*(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*

5. Check all that apply to you:
- Am a female between ages 18 and 49 years old
  - Am a male between ages 12 and 29 years old
  - Have a history of myocarditis or pericarditis
  - Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
  - Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
  - Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
  - Have a weakened immune system (i.e., HIV infection, cancer)
  - Take immunosuppressive drugs or therapies
  - Have a bleeding disorder
  - Take a blood thinner
  - Have a history of heparin-induced thrombocytopenia (HIT)
  - Am currently pregnant or breastfeeding
  - Have received dermal fillers
  - Had a positive test for COVID-19 or been told by a doctor that you had Covid-19

I, the undersigned, certify that all of the above information is correct to the best of my knowledge.

Signature

Date

Relationship to person named on this form:





# COVID-19 VACCINE SCREENING FORM

2020-2021

County of San Luis Obispo Public Health Department

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## Acknowledgment of Vaccine Information, Privacy Practices, and Self-Attestation

I have read or had explained to me the **COVID-19 Vaccine Information Statement**. I have had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and request that it to be given to me or to the person for whom I am authorized to make this request.

Link for Pfizer BioNTech **COVID-19 Vaccine Information Statement**: <https://www.fda.gov/media/144414/download>

Link for Moderna **COVID-19 Vaccine Information Statement**: <https://www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-recipients.pdf>

Link for Janssen (J&J) **COVID-19 Vaccine Information Statement**: [https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/COVID-19/JnJ\\_factsheet.pdf](https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/COVID-19/JnJ_factsheet.pdf)

I hereby acknowledge that I have been offered or have received a copy of San Luis Obispo County Health Agency's Notice of Private Practices. I further acknowledge that a copy of the current notice is posted in the reception area of each clinic and I will be offered a copy.

Signature (Patient) \_\_\_\_\_ Date \_\_\_\_\_

Signature (Parent or Guardian) \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Name - PLEASE PRINT

\_\_\_\_\_  
Name - PLEASE PRINT

### Phone Consent / Video Call Consent for 12-17 y/o

Witness Name / Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent / Guardian Name \_\_\_\_\_

~Do Not Write Below This Line~

Medical Evaluation By:
_____
Print Name
_____
Full Signature & suffix
_____

Administered By:
_____
Print Name
_____
Full Signature & suffix
_____

Injection Site:

Vaccinate?
Yes    No
<input type="checkbox"/> <input type="checkbox"/>

Vaccine Lot

[Affix Label Here]
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