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January 12, 2021

The Ohkay Owingeh Health & Human Services Division is pleased to inform you that the Covid Vaccine is now being made available to tribal and community members. This is available per the Indian Health Service; who is following CDC guidelines. They began with essential workers and are now finishing up with the 75 year and older group. Our Ohkay Owingeh H&HS department is working with IHS in this very important task by tracking those individuals within the categories to be scheduled for a shot.

Indian Health Service designates the date and time for providing the Covid vaccine and informs us as soon as they have it confirmed. They will also decide the site for the clinic and how their vaccine process will run for that time and date. Our department has a very short turnaround time with which to review who meets their guidelines to receive the shot on that date. Our staff will call individuals in the category to ask if they agree to get the Covid shot and inform them of the date, time, and process.

We are working with our tribal departments to identify community members and need your most current phone number, date of birth, address, and correct spelling of your name. This is crucial in getting you scheduled in a timely manner. You will be required to fill out paperwork before you receive the vaccine; these packets are available at the Community Health Representative (CHR) office or you may print packet from the website.

We are asking that individuals inquiring to get on a Covid vaccine list to call only during the following times: **Monday – Friday 9:00 a.m. – 11:00a.m. to (505)852-6193**
Just a reminder that despite receiving your Covid shot, everyone should and must continue to adhere to the recommended guidelines of wearing a mask whenever you leave your homes, washing your hands often for 20 seconds, stay 6 ft away from others, and avoid greater than 5 individuals gathering at a time.

Thank you and Stay Well!
Ohkay Owingeh Health & Human Services Division

Pharmacovigilance Drug Safety Alert



V-Safe After Vaccination Health Checker



V-safe is a smartphone-based tool developed by the CDC that uses text messaging and web surveys to conduct electronic health check-ins with participants who have received a COVID-19 vaccine.

Electronic health check-ins will take place:

- daily for first week post-vaccination
- weekly thereafter until 6 weeks post-vaccination
- additional checks at 3-, 6-, and 12-months post-vaccination

Electronic health check-ins will:

- Provide an opportunity for participants to report any side effects or health problems after COVID-19 vaccination.
 - If reports result in significant health impact, the CDC will follow-up by phone and create a VAERS report if appropriate.
- Capture information on pregnancy status and enable follow-up on pregnant women.
- Remind participants when it is time to get their second dose of COVID-19 vaccine if needed.

To register, visit: [CDC v-safe website](#)

The CDC asks that healthcare providers:

- Give a one-page enrollment sheet to patients at the time of vaccination.
- Counsel patients on the importance of enrolling in v-safe.

Participation in v-safe is voluntary and patients can opt out at any time. Consider placing v-safe posters and materials in clinic rooms and locations where the COVID vaccine may be administered.

Learn more information about using the [v-safe after vaccine health checker](#).

To help track safety issues with vaccinations, please report adverse vaccine events involving to the VAERS program as recommended in the [Indian Health Manual](#). Instructions for reporting can be found online at the [NPTC Pharmacovigilance website](#).



Get vaccinated. Get your smartphone. Get started with v-safe.

What is v-safe?

v-safe is a smartphone-based tool that uses text messaging and web surveys to provide personalized health check-ins after you receive a COVID-19 vaccination. Through **v-safe**, you can quickly tell CDC if you have any side effects after getting the COVID-19 vaccine. Depending on your answers, someone from CDC may call to check on you. And **v-safe** will remind you to get your second COVID-19 vaccine dose if you need one.

Your participation in CDC's **v-safe** makes a difference—it helps keep COVID-19 vaccines safe.

How can I participate?

Once you get a COVID-19 vaccine, you can enroll in **v-safe** using your smartphone. Participation is voluntary and you can opt out at any time. You will receive text messages from **v-safe** around 2pm local time. To opt out, simply text "STOP" when **v-safe** sends you a text message. You can also start **v-safe** again by texting "START."

How long do v-safe check-ins last?

During the first week after you get your vaccine, **v-safe** will send you a text message each day to ask how you are doing. Then you will get check-in messages once a week for up to 5 weeks. The questions **v-safe** asks should take less than 5 minutes to answer. If you need a second dose of vaccine, **v-safe** will provide a new 6-week check-in process so you can share your second-dose vaccine experience as well. You'll also receive check-ins 3, 6, and 12 months after your final dose of vaccine.

Is my health information safe?

Yes. Your personal information in **v-safe** is protected so that it stays confidential and private.*



Use your smartphone
to tell CDC about
any side effects after
getting the COVID-19
vaccine. You'll also get
reminders if you need a
second vaccine dose.



Sign up with your
smartphone's browser at
vsafe.cdc.gov

OR

Aim your smartphone's
camera at this code



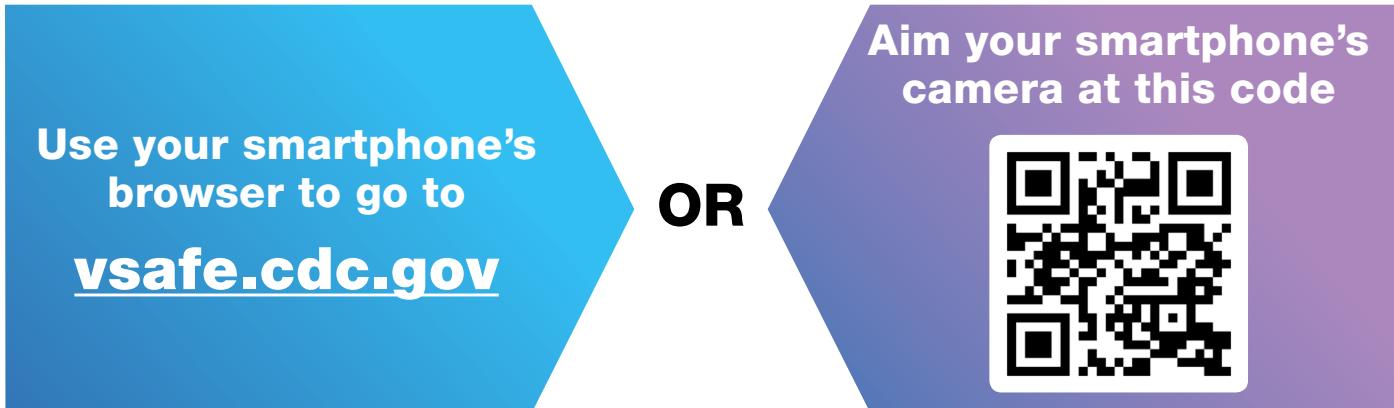
*To the extent **v-safe** uses existing information systems managed by CDC, FDA, and other federal agencies, the systems employ strict security measures appropriate for the data's level of sensitivity. These measures comply, where applicable, with the following federal laws, including the Privacy Act of 1974; standards enacted that are consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Federal Information Security Management Act, and the Freedom of Information Act.

How to register and use v-safe

You will need your smartphone and information about the COVID-19 vaccine you received. This information can be found on your vaccination record card; if you cannot find your card, please contact your healthcare provider.

Register

1. Go to the **v-safe** website using one of the two options below:



2. Read the instructions. Click **Get Started**.
3. Enter your name, mobile number, and other requested information. Click **Register**.
4. You will receive a text message with a verification code on your smartphone. Enter the code in **v-safe** and click **Verify**.
5. At the top of the screen, click **Enter your COVID-19 vaccine information**.
6. Select which COVID-19 vaccine you received (found on your vaccination record card; if you cannot find your card, please contact your healthcare provider). Then enter the date you were vaccinated. Click **Next**.
7. Review your vaccine information. If correct, click **Submit**. If not, click **Go Back**.
8. **Congrats! You're all set!** If you complete your registration before 2pm local time, **v-safe** will start your initial health check-in around 2pm that day. If you register after 2pm, **v-safe** will start your initial health check-in immediately after you register—just follow the instructions.

You will receive a reminder text message from **v-safe** when it's time for the next check-in—around 2pm local time. Just click the link in the text message to start the check-in.

Complete a v-safe health check-in

1. When you receive a **v-safe** check-in text message on your smartphone, click the link when ready.
2. Follow the instructions to complete the check-in.

Troubleshooting

How can I come back and finish a check-in later if I'm interrupted?

- Click the link in the text message reminder to restart and complete your check-in.

How do I update my vaccine information after my second COVID-19 vaccine dose?

- **V-safe** will automatically ask you to update your second dose information. Just follow the instructions.

Need help with v-safe?

Call 800-CDC-INFO (800-232-4636)
TTY 888-232-6348
Open 24 hours, 7 days a week
Visit www.cdc.gov/vsafe



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 16 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.

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 16 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

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

FDA has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine in individuals 16 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 20,000 individuals 16 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?

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

- injection site pain
- tiredness
- headache
- muscle pain
- chills
- joint pain
- fever
- injection site swelling
- injection site redness
- nausea
- feeling unwell
- swollen lymph nodes (lymphadenopathy)

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.

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

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.

Website	Fax number	Telephone number
www.pfizersafetyreporting.com	1-866-635-8337	1-800-438-1985

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. FDA may allow the emergency use of other vaccines to prevent COVID-19.

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.

Global website	Telephone number
www.cvdvaccine.com 	1-877-829-2619 (1-877-VAX-CO19)

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>.

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/ 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-1451-0.7

Revised: December 2020



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

Barcode Date: 12/2020

Pre-Vaccination Checklist for COVID-19 Vaccines



For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the 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 may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Patient Name _____

Age _____

Yes No Don't know

1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine? <ul style="list-style-type: none">• If yes, which vaccine product? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Another product _____			
3. Have you ever had a 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 the hospital? <ul style="list-style-type: none">• Was the severe allergic reaction after receiving a COVID-19 vaccine?• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

Form reviewed by _____

Date _____

Pre-Vaccination Checklist for COVID-19 Vaccines

Information for Healthcare Professionals



For additional information on COVID-19 vaccine clinical guidance, see: <https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html>.

For additional information on ACIP general recommendations, see: <https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html>.

Two COVID-19 vaccines are currently authorized for use in the United States. These vaccines are authorized for use among different age populations.

PRODUCT	AUTHORIZED AGE GROUPS
Pfizer-BioNTech COVID-19 Vaccine	16 years of age and older
Moderna COVID-19 Vaccine	18 years of age and older

Anyone outside of the authorized age groups for a product should not receive the vaccine.

Are you feeling sick today?

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. **Mild illnesses (e.g., upper respiratory infections, diarrhea) are NOT contraindications to vaccination.** Do not withhold vaccination if a person is taking antibiotics.

Vaccination of persons with current SARS-CoV-2 infection should be deferred until the person has recovered from acute illness and they can discontinue isolation. This recommendation applies to persons who develop SARS-CoV-2 infection before receiving any vaccine doses as well as those who develop SARS-CoV-2 infection after the first dose but before receipt of the second dose.

Have you ever received a dose of COVID-19 vaccine?

COVID-19 vaccines are **NOT** interchangeable. Currently authorized COVID-19 vaccines require two doses. Both doses of the series should be completed with the same product. Product dosing schedules vary.

Check medical records, immunization information systems, and vaccination record cards to help determine the initial product received. Those who received a trial vaccine should consult with the trial sponsors to determine if it is feasible to receive additional doses.

PRODUCT	DOSING SCHEDULE Between doses 1 and 2
Pfizer-BioNTech COVID-19 Vaccine	21 days
Moderna COVID-19 Vaccine	28 days

The second dose should be administered as close to the recommended interval as possible. The vaccine can be given up to four days in advance of the recommended interval if a patient presents early and you are concerned they will not return at the appropriate interval for vaccination. However, there is no maximum interval between the first and second dose for either vaccine. The series does not need to be restarted.

Pre-Vaccination Checklist for COVID-19 Vaccines

Information for Healthcare Professionals



COVID-19 Vaccine Components

Description	Pfizer-BioNTech COVID-19 vaccine	Moderna COVID-19 vaccine
mRNA	Nucleoside-modified mRNA encoding the viral spike (S) glycoprotein of SARS-CoV-2	Nucleoside-modified mRNA encoding the viral spike (S) glycoprotein of SARS-CoV-2
Lipids	2[(polyethylene glycol)-2000]-N, N-ditetradecylacetamide	Polyethylene glycol (PEG) 2000 dimyristoyl glycerol (DMG)
	1,2-distearoyl-sn-glycero-3-phosphocholine	1,2-distearoyl-sn-glycero-3-phosphocholine
	Cholesterol	Cholesterol
	(4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl) bis(2-hexyldecanoate)	SM-102 (Proprietary to Moderna)
Salts, sugars, buffers	Potassium chloride	Tromethamine
	Monobasic potassium phosphate	Tromethamine hydrochloride
	Sodium chloride	Acetic acid
	Dibasic sodium phosphate dihydrate	Sodium acetate
	Sucrose	Sucrose

Have you ever had a 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 the hospital?

Allergic reactions, including severe allergic reactions, NOT related to vaccines or injectable therapies (e.g., food, pet, venom, environmental, or latex allergies; oral medications) are NOT a contraindication or precaution to vaccination with currently authorized COVID-19 vaccine. HOWEVER, individuals who have had severe allergic reactions to something, regardless of cause, **should be observed for 30 minutes after vaccination**. All other persons should be observed for 15 minutes.

Was the severe allergic reaction after receiving a COVID-19 vaccine?

History of severe allergic reaction (e.g., anaphylaxis) to a previous dose or component of the COVID-19 vaccine product being offered is a contraindication to any current COVID-19 vaccine. Ask questions about previous severe reactions that might indicate an allergy to a vaccine component. For example, PEG may have been a component of medication for a colonoscopy.

Was the severe allergic reaction after receiving another vaccine or another injectable medication?

History of severe allergic reaction (e.g., anaphylaxis) to another vaccine or a component of another vaccine OR anaphylactic reaction to any other injectable medication is a **precaution to currently authorized COVID-19 vaccine**. Vaccine may be given, but counsel patients about unknown risks of developing a severe allergic reaction and balance these risks against the benefits of vaccination. These individuals should be observed for 30 minutes after vaccination. A history of mild allergic reaction to a vaccine or injectable therapy is not a precaution to vaccination.

Healthcare professionals should be familiar with identifying immediate-type allergic reactions, including anaphylaxis, and be competent in treating these events at the time of vaccine administration.

Appropriate medical treatment for severe allergic reactions must be immediately available in the event that an acute anaphylactic reaction occurs following administration of a COVID-19 vaccine.

See [Management of Anaphylaxis at COVID-19 Vaccination Sites](#) | CDC for additional guidance.

Have you received passive antibody therapy as treatment for COVID-19?

Based on the estimated half-life of monoclonal antibodies or convalescent plasma as part of COVID-19 treatment, as well as evidence suggesting that reinfection is uncommon in the 90 days after initial infection, **vaccination should be deferred for at least 90 days**, as a precautionary measure until additional information becomes available, to avoid interference of the antibody treatment with vaccine-induced immune responses.

Pre-Vaccination Checklist for COVID-19 Vaccines

Information for Healthcare Professionals



Clinical Consideration Questions

Responses to these questions are not (on their own) contraindications or precautions to vaccination. However, healthcare professionals should be prepared to discuss information and options with patients based on their responses to the following questions.

Have you received another vaccine in the last 14 days?

COVID-19 vaccine series should be administered alone, with a minimum interval of 14 days before or after administration with other vaccines. This recommendation is based on the lack of data on the safety and efficacy of mRNA COVID-19 vaccines administered simultaneously with other vaccines.

Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?

Vaccination should be offered to persons regardless of history of prior symptomatic or asymptomatic SARS-CoV-2 infection. Vaccination of persons with known current SARS-CoV-2 infection should be deferred until the person has recovered from the acute illness (if the person had symptoms) and criteria have been met for them to discontinue isolation.

Persons with documented acute SARS-CoV-2 infection in the preceding 90 days may delay vaccination until near the end of this period, if desired, because current evidence suggests reinfection is uncommon during this time.

Viral testing to assess for acute SARS-CoV-2 infection or serologic testing to assess for prior infection solely for the purposes of vaccine decision-making is not recommended.

Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?

Persons with HIV infection or other immunocompromising conditions, or who take immunosuppressive medications or therapies might be at increased risk for severe COVID-19. mRNA COVID-19 vaccines may be administered to persons with underlying medical conditions who have no contraindications to vaccination. However, they should be counseled about the unknown vaccine safety profile and effectiveness in immunocompromised populations, as well as the potential for reduced immune responses and the need to continue to follow all current guidance to protect themselves against COVID-19, including wearing a mask, social distancing, and washing hands frequently.

Do you have a bleeding disorder or are you taking a blood thinner?

COVID-19 vaccine may be given to these patients, if a physician familiar with the patient's bleeding risk determines that the vaccine can be administered intramuscularly with reasonable safety. ACIP recommends the following technique for intramuscular vaccination in patients with bleeding disorders or taking blood thinners: a fine-gauge needle (23-gauge or smaller caliber) should be used for the vaccination, followed by firm pressure on the site, without rubbing, for at least 2 minutes.

Are you pregnant or breastfeeding?

If pregnant people are part of a group that is recommended to receive a COVID-19 vaccine (e.g., healthcare personnel), they may choose to be vaccinated. For pregnant people seeking guidance in making a decision, pregnant people and their healthcare providers should consider the level of COVID-19 community transmission, the patient's personal risk of contracting COVID-19, the risks of COVID-19 to the patient and potential risks to the fetus, the efficacy of the vaccine, the side effects of the vaccine, and the lack of data about the vaccine during pregnancy.

A lactating person who is part of a group recommended to receive a COVID-19 vaccine (e.g., healthcare personnel) may choose to be vaccinated. There are no data on the safety of COVID-19 vaccines in lactating people or the effects of mRNA COVID-19 vaccines on the breastfed infant or milk production/excretion.

COVID-19 Vaccination Patient Record

For Documentation in Vaccine Administration Management System (VAMS)

This document facilitates capture of data required for documentation in VAMS

Patient or Patient Representative to complete this section

Today's Date	First Name (Print)*	Last Name (Print)*	Gender (select one)* <input type="checkbox"/> Female <input type="checkbox"/> Decline to Specify <input type="checkbox"/> Male <input type="checkbox"/> Other
Date of Birth*		Race* <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown/Not Reported	
Ethnicity*		Address	
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown/Not Reported		County of Residence	
Tribe of Membership		Phone	
COVID dose: <input type="checkbox"/> 1 st dose <input type="checkbox"/> 2 nd dose		If 2 nd dose, enter date and facility of 1 st dose:	
COVID-19 Vaccine Screening Questionnaire completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		COVID-19 Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS) received? <input type="checkbox"/> Yes <input type="checkbox"/> No	

*Field required for Vaccine Administration Management (VAMS) reporting

TO BE COMPLETED BY INDIVIDUAL ADMINISTERING VACCINE

Date COVID-19 vaccine administered:	Facility/Location:			
COVID-19 Vaccine Screening Questionnaire reviewed and vaccination administration deemed appropriate: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Precaution identified and vaccination in an alternate setting needed				
COVID dose: <input type="checkbox"/> 1 st dose <input type="checkbox"/> 2 nd dose	COVID-19 Vaccine Manufacturer: <input type="checkbox"/> Moderna <input type="checkbox"/> AstraZeneca <input type="checkbox"/> Pfizer <input type="checkbox"/> Johnson&Johnson <input type="checkbox"/> Novavax <input type="checkbox"/> Sanofi Pasteur <input type="checkbox"/> Other:	If 2 nd vaccine dose, manufacturer of 1 st dose: <input type="checkbox"/> Moderna <input type="checkbox"/> AstraZeneca <input type="checkbox"/> Pfizer <input type="checkbox"/> Johnson&Johnson <input type="checkbox"/> Novavax <input type="checkbox"/> Sanofi Pasteur <input type="checkbox"/> Other:	Lot Number:	Injection volume: <input type="checkbox"/> 0.3mL <input type="checkbox"/> 0.5mL
			Expiration:	
Immunization site: <input type="checkbox"/> Right Deltoid <input type="checkbox"/> Right Thigh (peds) <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Left Thigh (peds)		Date of Vaccine Information Statement (VIS) or Emergency Use Authorization (EUA) Fact Sheet:		Administration time:
Was today's vaccination administration successful? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is it possible to reattempt administration? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(this is a default question in VAMS and is likely not applicable to most IHS/Tribal/Urban organizations that are utilizing VAMS)</i>			Was any vaccine wasted during administration? <input type="checkbox"/> Yes <input type="checkbox"/> No If vaccine wasted select reason: <input type="checkbox"/> Broken Vial/Syringe <input type="checkbox"/> Vaccine drawn but not administered <input type="checkbox"/> Non-vaccine product (e.g. IG, HBIG, Dil) <input type="checkbox"/> Open vial but all doses not administered <input type="checkbox"/> Lost or unaccounted for vaccine <input type="checkbox"/> Other:	
<input type="checkbox"/> COVID vaccination documentation completed in VAMS <input type="checkbox"/> COVID vaccination documentation completed in Patient Medical Record				

Signature and Title of Vaccinator

Date

**Instructions for Completing COVID-19 Patient Record
For Vaccine Documentation in Vaccine Administration Management System (VAMS)**

Purpose of form:

1. Captures required data for documentation of vaccination into Vaccine Administration Management System (VAMS)
2. Serves as a record of COVID-19 vaccine administered to PATIENT
3. Utilized by sites that do not have electronic health record capable of sending required HL7 message to CDC

Form instructions:

1. Print legibly in all fields using dark permanent ink
2. Section I, to be completed by PATIENT or PATIENT REPRESENTATIVE
3. Section II, to be completed by healthcare professional who administers vaccine to recipient
4. Information from form must be electronically recorded in VAMS
 - a. Documentation in VAMS is to occur within 24 hours of vaccine administration
 - b. Vaccine administration must be documented by healthcare professional who administered the vaccine to the recipient
5. Completed form to be placed in Patient Health Record after documentation in VAMS



Acknowledgement of Receipt of IHS Notice of Privacy Practices

I hereby acknowledge of receipt of the Indian Health Services (IHS) Notice of Privacy Practices at:

Santa Fe Indian Hospital
1700 Cerrillos Road
Santa Fe, NM 87505

Signature of Patient

Date

Parent Signature if under 18 years

Date

Patient Registration Signature

Date

For Patients Unable to Acknowledge Receipt:

I hereby certify that the patient is unable to acknowledge receipt of the IHS Notice of Practices
Because:

Patient Registration Signature

Date



SANTA FE SERVICE UNIT

1700 CERRILLOS ROAD, SANTA FE, NM 87505

Patient Registration Form



Patient Information		Is this a Job Related Injury?		Y	N
Last	First	MI	Date of Birth	Marital Status M D S	
City/State of Birth		Sex	SSN	Current Community/How Long?	
Mailing Address		City	State	Zip	
Physical Address		City	State	Zip	
Cell Phone ()	Home Phone ()	Work Phone ()	Have you ever been seen at any of our Other clinics: (circle all that apply) 1. Santa Clara Clinic 2. San Felipe Clinic 3. Cochiti Clinic 4. Santo Domingo Clinic		
Religious Preference	Tribe of Membership	Tribe Quantum			
Indian Blood Quantum	Other Tribes	CIB/Enrollment			
Place of Employment Name & Address		City/State	Phone # ()		
Fathers Name, (Last, First, Middle)		Mothers Maiden Name (Last, First, Middle)			
Fathers Place of Birth (City & State)		Mothers Place of Birth (City & State)			
Father's Place of Employment (required for patients under 18 years)		Mother's Place of Employment (required for patients under 18 years)			
Emergency Contact Name		Phone # ()	Relationship		
Emergency Contact Address		City	State	Zip	
Next of Kin Name		Phone # ()	Relationship		
Next of Kin Address		City	State	Zip	
Insurance Information					
Do You have any of the following?		Medicare	Medicaid	Private Insurance	Workman's Comp
(Circle all that apply)		Tricare	Tricare For Life	Dental Insurance	
Please Provide a Copy of Insurance Card(s)					
Are you active Duty or a Dependent of Active Duty? Yes No	If Yes Circle the appropriate designation			If Active Duty or have Tricare, what Tricare Region are you Enrolled in?	
Commissioned Corps USPHS	Military DoD	Other Active Duty	West South North		
Are you a Veteran of the Armed Forces? Yes No	Do you receive or Qualify for Health Care Benefits at the VA? Yes No				
If yes what Branch?					
If you have none of the Third Party resources listed above, have you ever been screened by a Benefits Coordinator to see If you qualify for any third party assistance? Yes No					
TURN PAGE OVER-Continued					

If you have any of the listed resources on the previous page, please provide the following Insurance Information

Medical Insurance		Other Insurance	
Insurance Name		Insurance Name	
Policy Holder Name		Policy Holder Name	
Policy Holder Date of Birth		Policy Holder Date of Birth	
Group Name		Group Name	
Policy #	Group #	Policy #	Group #
Expiration Date		Expiration Date	
Dental Insurance		Pharmacy Insurance/ Medicare Part D Coverage	
Insurance Name		Insurance Name	
Policy Holder Name		Policy Holder Name	
Policy ID # or SS #		Policy ID # or SS #	
Group #		Group #	
Expiration Date		Expiration Date	
Previous Health Care			
Please list the clinic(s), Hospital or IHS Facility you receive your health care at before coming to Santa Fe Indian Hospital: (including out of state)			
Name of Facility		City/State	Phone # ()
Name of Facility		City/State	Phone # ()
Name of Facility		City/State	Phone # ()

New Chart Number _____ Registration Clerk Name _____

Santa Fe Service Unit

Adult Vaccine Consent Form

Name: _____

Chart Number: _____

Date of Birth: _____

Mother's Maiden Name: _____

I have been given and have read, or have had explained to me, the information in the "Vaccine Information Statement(s)" for the disease(s) and vaccine(s) checked below. I understand the benefits and risks of the vaccines requested and also understand that I have the alternative to decline vaccines. I ask that the vaccines signed for below be given to the person named for whom I am authorized. I understand that some immunizations are given in a series over a period of time and that by signing this form I agree that the immunizations marked below will be given, including those needed to complete a series. I agree to report any problems that arise, and direct any questions to the health care provider. I also understand that I may request from the health provider procedures on how to lawfully discontinue a vaccine series once begun. I agree to allow information on immunization(s) given to the named person to be released to other medical care provider(s) to avoid unnecessary vaccination or to ascertain immunization status. I also understand that my medical care provider may release this information to the state immunization registry (NMSIIS) unless I sign a document indicating my refusal.

X

Signature of person to receive vaccine or person authorized to make request

Date

BELOW FOR NURSE USE ONLY

ENTER THE APPROPRIATE LOT#, DATE of VIS AND SITE/ROUTE FOR EACH VACCINE GIVEN

Vaccine	Lot #	Date of VIS	Site/Route
COVID-19 Pfizer			
COVID-19 Moderna			

RA/IM (Right Arm/Intramuscular) LA/IM (Left Arm/Intramuscular) RT/IM (Right Thigh/Intramuscular) LT/IM (Left Thigh/Intramuscular)

VACCINATOR: _____
(PRINT NAME/TITLE)

_____ (SIGNATURE)

_____ (DATE OF SERVICE)

SANTA FE SERVICE UNIT-PHS INDIAN HOSPITAL
1700 Cerrillos Rd, SANTA FE, NEW MEXICO 87505
(505) 988-9821

SERVICE AGREEMENT

- 1. AUTHORIZATION FOR HOSPITAL CARE AND EMERGENCY ROOM TREATMENT:**
The Undersigned voluntarily agrees to treatment and services that his/her physician deems necessary.
- 2. RELEASE OF INFORMATION FOR BILLING SERVICES AND REVIEW:**
Santa Fe I.H.S. and Tribal Sites may disclose all or any reasonable part of the patient's record excluding information pertaining to medical history, mental or physical condition, alcohol/drug abuse and psychiatric diagnosis to any person or entity for the purpose of billing all or part of the hospital's charges to include but not limited to any person, insurance companies, employer, pre-admission review, utilization review, evaluation, financial audit for any other purposes reasonably related to these activities. The undersigned understands that this authorization will remain in effect for a long term period of inpatient and outpatient services, unless revoked in writing prior to that date.
- 3. ASSIGNMENT OF INSURANCE BENEFITS - PRIVATE HEALTH INSURANCE:**
I hereby authorize payment directly to the Santa Fe Service Unit for hospital benefits otherwise payable to me but not to exceed the hospitals regular charges for this period of services or hospitalization. Authorization is not limited to private health insurance but may include other sources such as Medicare/Medicaid, Liability claims and/or reimbursable insurance for my services I receive.
- 4. MEDICAID:**
State regulations require you to present a current identification card every time you are admitted or receive service. Every patient is required to submit an application for Medicaid if referred by a Physician, Benefits Coordinator, Contract Health Service or other provider. Lack of compliance with the Medicaid application process may result in a denial for Contract Health Service until an application is completed.
- 5. MEDICARE:**
This program covers hospitalization if it is determined that it is medically necessary for the patient to be admitted to receive health care. By signing this agreement I have given this facility a "Statement of Permit for Payment of Medicare Benefits to this Provider" it is my understanding that the Professional Review Organization and its agents may receive information needed to determine benefits payable.
- 6. NON-BENEFICIARY FINANCIAL AGREEMENT for Emergency Services ONLY:**
The undersigned agrees individually as follows: That in consideration for the services rendered to the patient, he/she obligates himself/herself and the patient to pay the account of the hospital in accordance with the regular rates and terms of this hospital. Any cost denied by an insurance agent or other responsible party, including co-payments and deductibles will be the responsibility of the parent/patient or guardian. Medicaid: If you do not identify yourself as a Medicaid recipient, you will be responsible for this bill. You will also be responsible for the Emergency Room charges for all Non-Emergency visits. Services not paid or covered under the Medicaid program will be billed to the patient or Guardian. Medicare: You are expected to pay the Medicare deductible and co-insurance. If for some reason your hospitalization does not meet the requirement of your insurance agency you will be responsible for the entire bill. **If you Do Not have on File a Certificate of Indian Blood (CIB) nor present proof of Eligibility from a Federally Recognized Tribe (IHS Circular Part 2 Ch 1 2-1.1) within 30-days; you will be billed for all services rendered and thereafter, You will Not be allowed to receive further services until proof is Provided.**
initial
- 7. PATIENT RIGHTS AND RESPONSIBILITIES:**
Patient Rights and Responsibilities have been explained to me and I understand my rights as a patient or guardian. Advance Directives has been briefly explained to me and if I should have any questions, I must speak with my Physician or other designated Advance Directives liaison. Privacy Act: I have been given notice and read the Privacy Act Notice and the laws, which govern my rights as a patient. Additional, I was given information of where I may obtain additional Information on Advance Directives. I acknowledge I DO [] DO NOT [] Have an advance Directive
- 8. PURCHASED/REFERRED CARE (PRC)**
I fully understand my responsibility under the CHS regulations. I understand the CHS is not an insurance program or an entitlement program. I must notify CHS within 72 hours or obtain Prior Approval for CHS services. I understand that I must comply with the regulations outlined under the alternate resource notice.
initial
- 9. AGREEMENT:**
By signing this form I understand the contents of the service agreement and have received a copy. Interpreting of this agreement was explained to me in English and/or in my native language.

Patient's/Guardian/Guarantor Signature _____ Date _____

Patient Name: _____

Interviewer's Signature _____ Date _____

Chart No: _____