Shasta County Health & Human Services Agency | Public Health Branch

Health Advisory #22:
COVID-19 Vaccination of Health Care Personnel, Shasta County
January 11, 2021

Please distribute to all providers in the facility

Go to https://www.co.shasta.ca.us/ready/covid-19/professionals for an electronic version of this Health Advisory

FOR SHASTA COUNTY PROVIDERS ONLY

Background

COVID-19 vaccine is currently allocated at the county level by the California Department of Public Health, with the exception of federal allocations by the Indian Health Service and the Veterans Administration. Vaccine can only be administered by providers enrolled in the state's COVID-19 Vaccination Program: previously COVIDReadi and, as of January 11, CalVAX. The status of vaccine administration in Shasta County can be found here: Shasta Ready - COVID-19 - Vaccinations.

Our priority is to ensure timely vaccination of Shasta County health care personnel, with a current focus on urgent care and primary care providers (FP, IM, Ob/GYN, Peds) (Tier 2). There are two strategies to meet this goal as outlined below.

Specialty clinics (medical and surgical specialists, optometrists, chiropractors, etc.), laboratories, dental offices, pharmacy and mortuary staff (Tier 3) will be scheduled soon and as vaccine supplies allow.

1) Adopt a Facility Program

Shasta County providers that are currently enrolled in the COVID-19 Vaccination Program have agreed to adopt the clinics listed in the table below. The adopting facility and/or public health will be in touch with your office to coordinate scheduling of your staff over the coming week. If your facility is listed below and you have questions in the interim, please contact: COVID19@co.shasta.ca.us.

Shasta Community Health Center (estimated numbers)	**Hill Country (estimated numbers)**	**Shingletown Medical Center Mayers Memorial**	**Shasta County Public Health Clinic**
Facility	Facility	Facility	Facility
Pulse Urgent Care (44) California Medical Group (25) Anderson Walk-In Clinic (30) Hilltop Medical Group (35) *Excellence in Healthcare** *Prestige** *Cascade Family Medical** *Redding Occupational**	Fusion (6) Paradigm (15)	Area health care personnel, Phase 1a.	Women's Health Specialists (18) Dr. Vance Harris (3) Planned Parenthood* Note: (Mass Vax Clinic for IHSS and CHWs not affiliated with a clinic: Sat., January 16)

* Pending response to Public Health.

Dignity clinics will be administered by Mercy Medical Center, Redding.

Additional vaccine clinics and capacity are in development in collaboration with MMCR and SRMC, and as additional providers are enrolled in CalVAX.

2) Other Primary Care (FP, IM, Ob/GYN, Peds) Personnel - Safeway

Primary care personnel that are *not* listed in the table above are invited to schedule their vaccination at a local Safeway pharmacy by using the links outlined below. Appointments are only available to invited groups.

Clinic Details:

- **Clinic start date: Wednesday 1/13/21**
- **Clinic will continue until 2/26/21 (or further notice)**

****IMPORTANT REMINDERS for all Participants****

- **Participants are seen by appointment only. Please make an appointment by clicking on the corresponding links below**
- **Fill out the Consent Form AND CDC Pre-Vaccination Form prior to appointment (attached)**
- **Bring medical and prescription insurance card to clinic**
- **Wear short sleeve shirt if possible**
- **Do NOT attend clinic if you are feeling unwell or experiencing COVID symptoms**

Safeway Pharmacy (Shasta County) In-store COVID-19 Vaccine Clinic:

Store	Address	Phone Number	Schedule	Online Scheduling Links
Safeway 1954	2275 Pine St Redding 96001	(530)247-3040	**Monday-Friday** 10am-6:30pm (Lunch break 1-2pm)	https://mhealthsystem.com/1954covidclinic
Safeway 273	2601 Balls Ferry Rd Anderson 96007	(530)365-1010	**Monday-Friday** 10am-6:30pm (Lunch break 1-2pm)	https://mhealthsystem.com/0273covidclinic
Safeway 4178	37264 Main St Burney 96013	(530)335-4101	**Monday - Friday** 10am-5:30pm (Lunch break 1-2pm)	https://mhealthsystem.com/4178covidclinic
Safeway 1826	1070 E Cypress Ave Redding 96002	(530)222-8274	**Monday-Friday** 10am-6:30pm (Lunch break 1-2pm) **Sat and Sunday** 10am-4pm (Lunch break 1-2pm)	https://mhealthsystem.com/1826covidclinic

Informed Consent for Immunization with Inactivated Vaccine

❒M ❒F ❒Other

Last Name **First Name** **Middle** **Date of Birth** **Age** **Gender**

( ) -

Home Address **City** **State** **Zip** **Phone #** ❒**Home** ❒**Cell**

Which arm do you prefer for vaccine?	
(please circle) Left Right	**Primary Care Provider Name:** _____ **Vaccine requested:** _____ **Primary Care Provider Address:** _____

Enter weight IF LESS than 66 pounds: **Lbs.**

Screening Questionnaire: *Please answer questions by checking the boxes.*

Screening Questions – NOTE: IF COMPLETED ONLINE, REVIEW ANSWERS WITH PATIENT TO ENSURE NO CHANGES		**Yes**	**No**	
1.	Are you sick today?	❒	❒	
2.	Do you have a serious allergy to ANY medications or food (e.g. eggs, gelatin, thimerosal, neomycin, gentamicin, etc.)? If yes, please list: _____	❒	❒	
3.	Have you ever had a serious reaction or fainted after receiving any vaccination?	❒	❒	
4.	Do you have sensitivity to latex (e.g. gloves or bandages)?	❒	❒	
5.	Do you have a seizure disorder or a brain disorder? *(Tdap only)*	❒	❒	
6.	For women: Are you pregnant or are you considering becoming pregnant in the next month?	❒	❒	
7.	Do you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list: _____	❒	❒	
Immunization Needs – NOTE: COVID-19 VACCINE CANNOT BE ADMINISTERED WITH OTHER IMMUNIZATIONS		**Yes**	**No**	**Unsure**
8.	Please check all that apply to you: ❒ Asthma ❒ Diabetes ❒ Heart Disease ❒ Tobacco Smoker ❒ 65 Years or older If you checked any of the above, have you ever received a PNEUMOCOCCAL vaccine? If yes, when? _____	❒	❒	❒
9.	Patients 50 and older: Have you ever received the SHINGLES vaccine?	❒	❒	❒
10.	How many years has it been since your last TETANUS vaccine?	_____ yrs		❒
11.	Patients 45 and under: Have you received the HPV (Human Papillomavirus) vaccine?	❒	❒	❒
12.	Patients aged 11 to 23: Have you received a meningitis vaccine?	❒	❒	❒
13.	Please indicate which vaccine(s) you would like more information about? ❒ Hepatitis A ❒ Hepatitis B ❒ MMR (Measles, Mumps, Rubella) ❒ Travel Vaccines ❒ Other: _____			

Informed Consent: *Please read and sign.*

By my signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, where permitted by law or state/federal guidance, employed by Albertsons Companies or one of its affiliated pharmacies and to be contacted at the number provided above regarding other immunizations for which I am due or eligible to receive. I also release Albertsons Companies and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting or arising from my receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received, if applicable. 2) I may be responsible for payment after the date of service if the product or service is billed to my medical benefit. 3) I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient. 4) I will immediately alert the pharmacist of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine. 5) I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I should remain in the area for 15 minutes after the vaccination for observation. 7) I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") provided for the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). 8) I have been offered and/or provided a copy of the company's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA). 9) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting by my pharmacy or its business associate to an immunization registry, which may share my immunization data with others, and to my primary care physician, the authorizing physician, or the local Department of Health, if applicable, and I authorize these disclosures.

X _____ _____

Signature of Patient or Parent/Guardian of Minor Patient **Date**

For Pharmacy Use Only

Vaccine Name	**Lot #**	**Expiration Date**	**Manufacturer**	**Dose (ml)**	**Dose #**	**Route**	**Site** (circle)	**VIS/EUA Publication Date**
							R / L Deltoid	
							R / L Deltoid	
							R / L _____	
							R / L _____	

Signature of RPh: _____ Initials of Administrator: _____ Administration Date: _____ NPP Offered: ❒

RPh Signature indicates (1) VIS/EUA Provided and (2) Counseling offered *(Please circle)* **Accepted** **Declined**

Billing Info *(off-site only):* ❒Medicare (ID# including letters) or Medical (Name, ID#, Group#, Payer ID) if UHC) _____

Last 4 digits of SSN: _____

BIN:_____ PCN: _____ Group#: _____ ID#: _____

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?			
• If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ 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?			
• 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** _____