# COVID-19 VACCINE HIGH RISK SCREENING FORM

## PRIVACY ACT STATEMENT

**AUTHORITY:** DHA-IPM 20-004, "DoD Coronavirus Disease (COVID-19) Vaccination Program Implementation"; Public Law 104- 191, 10 U.S.C., Chapter Ch. 55, Medical and Dental Care;
**PURPOSE:** To determine patient COVID-19 vaccine high risk priority category.
**ROUTINE USES: I**nformation in your records may be disclosed to other components within the MHS for the purpose of continuing medical care and determining military readiness. Additionally, this information may be shared with the Departments of Veterans Affairs and Health and Human Services and other local, state, and federal public health agencies for the purposes of satisfying public health and vaccination reporting requirements and responding to the COVID-19 pandemic.
Any protected health information (PHI), including mental health and substance abuse information, in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoDM 6025.18. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations. A complete listing of the applicable routine uses may be found in the associated System of Records Notice (SORN).
**APPLICABLE SORN:** EDHA 07, Military Health Information System (June 15, 2020, 85 FR 36190)
https://dpcld.defense.gov/Portals/49/Documents/Privacy/SORNs/DHA/ EDHA-07.pdf
**DISCLOSURE:** Voluntary. If you choose not to provide your information, no penalty may be imposed, but there may be a delay in identifying your risk category.

The following questions will help us determine your risk category for the COVID-19 vaccination.

| **1. NAME (Last, First, Middle Initial)** | **2. DoD ID or Unique Identifier** | **3. DATE OF BIRTH (YYYYMMDD)** | **4. AGE** |
|---|---|---|---|
| **5. (DEPENDENTS ONLY) Sponsor's Name (Last, First, MI)** | **6. (DEPENDENTS ONLY) Sponsor's SSN** | **7. (DEPENDENTS ONLY) Sponsor's Date of Birth** | |
| **8. Patient Telephone number:** | | **9. Sponsor's Assigned Unit:** | |

**10. CATEGORY** Civilian Contractor ☐ Family Member (FM) ☐ Retiree FM ☐ GS Civilian FM ☐ NAF Employee FM ☐ Reservist FM ☐

| **HIGH RISK QUESTIONAIRE – COMPLETED BY PATIENT** (Have you been diagnosed with the Following conditions: ) | YES | NO |
|---|---|---|
| **(1)** Chronic Kidney Disease? | | |
| **(2)** COPD (chronic obstructive pulmonary disease)? | | |
| **(3)** Obesity (BMI of 30 or higher)? | | |
| **(4)** Immunocompromised state (weakened immune system) from solid organ transplant? | | |
| **(5)** Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies? | | |
| **(6)** Sickle cell disease? | | |
| **(7)** Type II diabetes? | | |
| **(8)** Are you over the age of 65? | | |
| **(9)** Will you still reside in the Stuttgart Military Community for the next six months? | | |
| **(10)** If you were to receive the 1st dose of the SAS-COV-2 Moderna vaccine would you be available 28 days later? | | |

**(11)** Please list any other medical conditions that may make you high risk

**(12).** ACKNOWLEDGMENT
I have read or answered each question truthfully and to the best of my ability and volunteer for the Corona virus vaccination under the Emergency Use Authorization (EUA) as a high risk category.

| a. PATIENT SIGNATURE: | b. DATE: |
|---|---|

Please send completed forms via ENCRYPTED DoD email to: usarmy.stuttgart.id-europe.list.covid-vaccination@mail.mil

May also submit via DoD Safe at https://safe.apps.mil/ to above address or bring form directly to AHC Stuttgart PAD section