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COVID-19 VACCINE INFORMATION FOR VESSELS CALLING STOCKTON AND WEST SACRAMENTO, CA

AS OF JUNE 09, 2021

STOCKTON: Effective 03-June-2021, Johnson & Johnson single dose vaccinations are available at no charge from San Joaquin Public Health Services for vaccination of crew onboard vessels calling the Port of Stockton. Intended vaccination schedule Mondays and Thursdays weekly, schedule subject to change. Estimate 1 – 1.5 hrs for entire procedure. TWIC escort currently required, to be arranged by agent, escort fee payable by Cash From Master direct to escort. Transworld Marine Services (Mike Shaikh) quotes $250 per vessel, max 2 hours per vessel. Gensteam Crew Medical Coordination Fee $35/crew (discount from $75 Tariff fee) payable by Cash From Master prior to departure.

Please:

1. Please advise number of crew requesting J & J single dose vaccination.
2. Please complete the attached Vaccination Consent Form for each crew member and present to nurse on arrival.
3. Please advise preferred language for Vaccination Fact Sheet, many languages available
4. Please provide Crew List in Excel/spreadsheet format for preparing vaccination cards.

WEST SACRAMENTO: Appointments can be made via vessel agent for Yolo County EMS administrator to attend vessel to vaccinate crew on board. The vaccine itself is free of charge, however TWIC escort required for nurse at cost and other coordination fees may apply.

Vaccines are also available at SF anchorage via launch before/after transit to Stockton/Sacramento.

Please contact David Ellsworth at our Stockton, CA office for additional information:

David Ellsworth
District Manager - Stockton
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FACT SHEET: **Johnson & Johnson COVID-19 Vaccine Benefits and Risks**

Understand the risks and benefits of receiving the single-dose Johnson & Johnson COVID-19 vaccine, which may prevent you from getting COVID-19. It is your choice to receive this vaccine. Talk to the vaccination provider if you have questions.

About this Vaccine

Like all COVID-19 vaccines, this vaccine has been authorized by the FDA for emergency use given the severity of the COVID-19 pandemic. This vaccine is a single dose injected into the muscle.

Before Getting the Vaccine

Tell the vaccination provider about all 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, breastfeeding, or plan to become pregnant
- have received another COVID-19 vaccine

You Should Not Get this Vaccine if:

You had a severe allergic reaction to any ingredient of this vaccine: recombinant, replication-incompetent adenovirus type 26 expressing the SARS-CoV-2 spike protein, citric acid monohydrate, trisodium citrate dihydrate, ethanol, 2-hydroxypropyl-β-cyclodextrin (HBCD), polysorbate-80, sodium chloride.

Benefits of this Vaccine

In an ongoing clinical trial, this vaccine has been shown to prevent illness, hospitalization or death from COVID-19 following a single dose. The duration of protection against COVID-19 is currently unknown.

Risks Associated with this Vaccine

- **General Side Effects:** Side effects reported with this vaccine include injection site reactions and headache, feeling very tired, muscle aches, nausea, and fever.
- **Severe Allergic Reaction:** There is a remote chance the vaccine could cause a severe allergic reaction (difficulty breathing, swelling of face and throat, fast heartbeat, bad rash all over your body, dizziness, weakness), which would usually occur a few minutes to one hour after getting the dose.
- **Blood Clots:** Blood clots involving blood vessels in the brain, abdomen, and legs; along with low levels of blood cells that help your body stop bleeding, have occurred rarely in some people who have received the Johnson & Johnson COVID-19 vaccine. In people who developed these blood clots, symptoms began approximately 1–2 weeks after vaccination and most were women under 50 years of age. You should seek medical attention right away if you have any of the following symptoms several days after receiving the vaccine: shortness of breath, chest pain, leg swelling persistent abdominal pain, severe headaches or blurred vision, easy bruising or tiny blood spots under the skin beyond the site of the injection.

If you Experience 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.

Other Options to Prevent COVID-19

It is your choice to receive this vaccine and not getting it will not change your standard medical care. Other vaccines to prevent COVID-19 are available.

More Information

Visit www.janssencovid19vaccine.com or www.cdc.gov/coronavirus

Call 1-800-565-4008 or (908) 455-9922

CDPH California Department of PublicHealth

Adapted from FDA Fact Sheet for Recipients and Caregivers

San Joaquin County Public Health Services
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2021 COVID-19 Vaccination Screening Form

Vaccine Manufacturer:
Johnson & Johnson (Janssen)

PATIENT (person receiving vaccine)

First Name:	Last Name:		MI:
Home Address:	City:	State:	Zip Code:
Date of Birth:	Gender:	Preferred Language:	
Occupation:	Cell Phone:	Email:	

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Asian Indian ☐ Chinese ☐ Black or African American ☐ White ☐ Unknown Race ☐ Other _____

Ethnicity: ☐ Hispanic or Latino _____ ☐ Not Hispanic or Latino _____ Unknown

Parent/Legal Guardian/Power of Attorney (necessary if patient is UNDER 18 years old) ☐

Name:	Phone Number:

Vaccination Consent:

This acknowledgment must be signed on the date the vaccine is administered by the person to receive the vaccine, or by the parent , legal guardian, or power of attorney.

I release San Joaquin County Public Health Services, 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 am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient. 3) 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. 4) I should remain in the area for observation for 15 minutes unless I have a history of an immediate allergic reaction of any severity to a vaccine or injectable therapy or if I have a history of anaphylaxis due to any cause I should remain in the area for observation for 30 minutes after the vaccination. If I leave the area without waiting, I acknowledge that I am doing so at my own risk and against the advice of the professional who administered the vaccine. 5) 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). 6) 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). 7) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting 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.

I understand the benefits and risks of the vaccine and request that the COVID-19 vaccine be given to me or to the person for whom I am authorized to make this request. I hereby provide informed consent to receiving 1-dose of the Johnson & Johnson (Janssen) COVID-19 Vaccine.

Patient Name:	Patient Signature:	Date:
Parent/Legal Guardian/Power of Attorney Name:	Parent/Legal Guardian/Power of Attorney Signature:	Date:

ADA Accommodations

☐ I do not require any accommodation during my appointment
☐ I require a companion or supporter to accompany me
☐ I require a service animal to accompany me
☐ I require extra time for my appointment
☐ I require assistance with reading or completing paperwork
☐ I require an assistive listening device
☐ I require material in the following alternative format: Braille, large print, audio, electronic format, another alternative format
☐ I require accommodations not listed above
☐ I require a qualified sign language interpreter

Is there anything else you would like us to know about the accommodations you are requesting?

San Joaquin County Public Health Services
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2021 COVID-19 Vaccination Screening Form

Vaccine Manufacturer: Johnson & Johnson (Janssen)

Screening Checklist for Contraindications to COVID-19 Vaccination	Dose #1	Dose #2
1. Have you been feeling sick in the last 7 days?	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you been diagnosed with COVID-19 in the past 7 days?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you ever received a dose of COVID-19 vaccine?	☐ Yes ☐ No	☐ Yes ☐ No
If YES, which vaccine product?		
4. Have you ever had a severe allergic reaction (e.g., anaphylaxis) in general, to a vaccine or other injectable medication?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you ever had a severe allergic reaction or anaphylaxis to food, medication, or an unknown substance? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?	☐ Yes ☐ No	☐ Yes ☐ No
6. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐ Yes ☐ No	☐ Yes ☐ No
7. Have you received another vaccine in the last 14 days?	☐ Yes ☐ No	☐ Yes ☐ No
8. Do you have a weakened immune system cause by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐ Yes ☐ No	☐ Yes ☐ No
9. Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes ☐ No	☐ Yes ☐ No
10. Are you pregnant or breastfeeding?	☐ Yes ☐ No	☐ Yes ☐ No

For Administrative Use Only

Dose 1	**Date Given:**	**Manufacturer:**	**Lot #:**	**Expiration Date:**
	Injection Site: ☐ L ☐ R	**Vaccinator name (print):**		**Initials & Date Entered into MyTurn/HF:**
Dose 2	**Date Given:**	**Manufacturer:**	**Lot #:**	**Expiration Date:**
	Injection Site: ☐ L ☐ R	**Vaccinator name (print):**		**Initials & Date Entered into MyTurn/HF:**

Comments