



COMMONWEALTH of VIRGINIA

HAROLD W. CLARKE
DIRECTOR

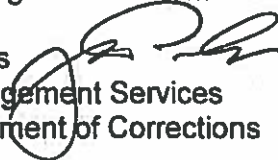
Department of Corrections

P. O. BOX 26963
RICHMOND, VIRGINIA 23261
(804) 674-3000

March 3, 2021

MEMORANDUM

To: Sheriffs and Regional Jail Administrators

From: James E. Parks 
Offender Management Services
Virginia Department of Corrections

Subject: COVID-19 Vaccinations and Jail Intake

As we prepare to resume jail intake over the next few weeks, the Department asks for your assistance in the area of inmate vaccinations and the scheduling of intakes. In an effort to ensure that the inmate population gets vaccinated to the greatest extent possible, our Intake staff will be requesting information as to whether inmates have been vaccinated, when and with which vaccine. The DOC has the Moderna vaccine only and the present guidance is to not mix vaccinations. We would request that inmates that have received a Pfizer COVID-19 vaccine not be sent to the DOC until they have received the second/final dose. Accommodating this request will not affect the number of beds that your jail will be offered for intake into the DOC.

I appreciate your understanding and assistance in this matter. Feel free to contact me at james.parks@vadoc.virginia.gov or (804) 887-7991 if you have any questions.

cc: J. Hastings, Intake Unit

COVID-19 Offender Questionnaire for Entry into DOC Facility

This screening questionnaire is intended to prevent the spread of COVID-19 and reduce the potential risk of exposure to employees, offenders, volunteers, visitors, families and public. Your participation is an important precautionary measure as offenders move from jails to VADOC facilities. This form **MUST** be completed for all offenders prior to transportation to a DOC facility.

Offender Name:	Offender's DOC Number:
Date of Birth:	Jail:

1.	Has the offender had close contact with someone diagnosed with COVID-19 within the last 14 days? <div style="text-align: center;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div>
2.	Has the offender had COVID-19? <div style="text-align: center;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> If so, when? _____
3.	Has the offender ever had a COVID-19 test? _____ If so, when? _____ Results _____ Repeat test date _____ Results _____ Repeat test date _____ Results _____
4.	Has the offender been fully or partially vaccinated against COVID-19? No _____ No, but is scheduled to be vaccinated on _____ Yes – first of two doses _____ (date of first dose) Manufacturer _____ Lot Number _____ Yes – both doses _____ (date of final dose) <input type="checkbox"/> Vaccination(s) entered into Virginia Immunization Information System (VIIS)
5.	Has the offender experienced any of the following symptoms in the last 14 days? Fever or sense of fever <input type="checkbox"/> Yes <input type="checkbox"/> No Cough <input type="checkbox"/> Yes <input type="checkbox"/> No Sore Throat <input type="checkbox"/> Yes <input type="checkbox"/> No Congestion or Runny Nose <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath or Difficulty breathing <input type="checkbox"/> Yes <input type="checkbox"/> No Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No Chills or Repeated shaking with chills <input type="checkbox"/> Yes <input type="checkbox"/> No Muscle pain <input type="checkbox"/> Yes <input type="checkbox"/> No Headache <input type="checkbox"/> Yes <input type="checkbox"/> No New loss of taste or smell <input type="checkbox"/> Yes <input type="checkbox"/> No Nausea or Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No Abdominal pain <input type="checkbox"/> Yes <input type="checkbox"/> No If the offender has any of the above mentioned symptoms, what is the onset date of first symptoms: _____

6.	<p>Is the offender currently under doctor's care for any illness?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES please explain. Does he need follow-up care?</p>
7.	<p>Is the offender insulin dependent?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
8.	<p>Has the offender had any incidents of self-injurious behavior or suicide attempts requiring outside medical intervention or homicidal ideation during the past 12 months?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
9.	<p>Is the offender currently seeing a mental health provider or therapist?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES: How often does the offender see the provider/therapist? _____</p>
10.	<p>Is the offender currently taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>List medications:</p>
11.	<p>Have any of the offender's medications changed over the past 60 days? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name of medication: _____</p>
12.	<p>Does the offender have any pending court matters? (e.g. juvenile and domestic, general district, circuit court?)</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Jail/Medical Staff: _____ Date: _____

Jail Staff: Please follow these instructions based on completion of your review of the offender:

- If the answer is "Yes" to any of the above questions, except #3 and #4, please notify the requesting Intake Section employee ASAP.
- If the answer is "No" to all of the above questions, except #3 and #4, please scan and email this completed form to the requesting Intake Section employee. Please note the date and time of your scan/email here:
 - Scan/email date: _____
 - Scan/email time: _____

Intake Section Employee: _____

Telephone Number: _____

Email address: _____