Prevaccination Checklist for COVID-19 Vaccines

Patient Name: _____ Age: ____

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.

	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 did you receive? O Pfizer O Janssen (Johnson & Johnson) O Another product			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen@ or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
A component of a COVID-19 vaccine including either of the following:			
Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
A previous dose of COVID-19 vaccine.			
A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen@ or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Form reviewed by _____Date_____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists

COVID Vaccine Consent Form

Consent

I have been provided and have read, or had explained to me, the information sheet abbut the COVID-19 vaccination. I understand that this vaccine requires 2 doses. 2 doses wil need to be administered (given) in order for it to be effective. I have been given the opportunity to ask questions which were answered to my satisfaction (and ensure the person named below for whom I am authorized to provide surrogate consent was also given the chÅnce to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named below for whom I authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, inc uding benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

Re ipient/Surrogate/Guardian (Signature) Date/Time Print Name Relationship to patient

Telephonic Interpreter's ID # Date/Time

Signature Interpreter Date/Time Print Interpreter's Name and Relationship to Pt