

Prevaccination Checklist for COVID-19 Vaccination



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.

Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever received a dose of COVID-19 vaccine? <ul style="list-style-type: none"> If yes, which vaccine product(s) did you receive? <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen <input type="checkbox"/> Another Product (Johnson & Johnson) _____ How many doses of COVID-19 vaccine have you received? _____ Did you bring your vaccination record card or other documentation? 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? <i>(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had an allergic reaction to: <i>(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 caused hives, swelling, or respiratory distress, including wheezing.)</i> <ul style="list-style-type: none"> A component of a COVID-19 vaccine, including either of the following: <ul style="list-style-type: none"> 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 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had an allergic reaction to another vaccine <i>(other than COVID-19 vaccine)</i> or an injectable medication? <i>(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 caused hives, swelling, or respiratory distress, including wheezing.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Check all that apply to you:			
<input type="checkbox"/> Am a male between ages 12 and 39 years old			
<input type="checkbox"/> Have a history of myocarditis or pericarditis			
<input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection			
<input type="checkbox"/> Have a bleeding disorder			
<input type="checkbox"/> Take a blood thinner			
<input type="checkbox"/> Have a history of Guillain-Barré Syndrome (GBS)			

Form reviewed by _____

Date _____

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

IMMUNIZATION SCREENING AND CONSENT FORM

PATIENT INFORMATION *(Please print clearly)*

Last Name: _____	First Name: _____	MI: _____	D.O.B.: _____	Age: _____	Gender: _____
Race/ Ethnicity: American Indian/Alaska Native Black/African American Hispanic/Latino Native Hawaiian/Other Pacific Islander White Asian Other					
Home Address: _____			Contact Phone: _____		
City: _____		State: _____		Zip: _____	
Primary Care Physician: _____			Physician Phone: _____		
Physician Address: _____			Physician Fax #: _____		

Which vaccine(s) would the patient like to receive today?

<input type="checkbox"/> Influenza (Injectable)	<input type="checkbox"/> Hepatitis A & B	<input type="checkbox"/> Meningococcal	<input type="checkbox"/> MMR
<input type="checkbox"/> Influenza (Nasal)	<input type="checkbox"/> HPV	<input type="checkbox"/> Td	<input type="checkbox"/> Varicella
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Zoster (Shingles)	<input type="checkbox"/> DTaP	<input type="checkbox"/> IPV
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Tdap	<input type="checkbox"/> Hib
<input type="checkbox"/> Other: _____			

I certify that I am: (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of "_____" to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by the applicable Provider to the State Registry by using the opt-out form. The Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at "_____" to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at "_____", my Primary Care Physician, my insurance and/or state or federal registries, where required, for the purpose of treatment, payment or other healthcare operations. I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service.

PATIENT NAME: _____
(Please print clearly)

PATIENT SIGNATURE: _____ *(Parent or guardian, if minor)* **DATE:** _____