Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

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? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ 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:			
o Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
o 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

Lakeside North
38 Rowe Drive
Guntersville, Alabama 35976

Date: _____ Paperwork Completed by: _____ Preferred Pharmacy: _____

PATIENT Name-Last: _____ First: _____ Middle: _____

Date of Birth: _____ Sex: ____M _____F SS#: _____ Race: _____

Ethnicity: _____ Marital Status: _____ Address: _____

City: _____ State: _____ Zip: _____ Home Phone: ( ) _____

Work: ( ) _____ Cell: ( ) _____ Email: _____ Preferred Communication: _____

Employer: _____ Employer Phone: _____ Occupation: _____

INSURANCE Carrier: _____ Policy Number: _____ Group Number: _____

Policy Holder: _____ Policy Holder DOB: _____

Secondary Insurance Carrier: _____ Policy Number: _____

Emergency Contact: _____ Telephone: _____ Relationship: _____

IF MINOR

Father's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer Phone: _____

Mother's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer Phone: _____

PRIVACY COMPLIANCE

Please list the family members or other persons, if any, we may inform about your general medical condition and your diagnosis, which might include medical history, treatment, lab reports, x-rays, and treatment and/or reference to any mental or nervous disorders, drug and /or alcohol abuse, or sexually transmitted disease and billing inquiries.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

***Can confidential messages be left on your home answering machine or voice mail (for ex—appointment info)?** Yes ____ No ___

I hereby authorize Lakeside North to furnish to my primary physician and insurance company(s) all information which said physician or insurance company(s) may request. I hereby assign to Lakeside North all money to which I am entitled for medical/surgical expense relative to the services rendered but not to exceed my indebtedness to the professional company. I understand that I am financially responsible for all charges whether or not paid by said insurance. I agree to pay 27.00% of principal balance for collection costs should account be placed with a collection agency or attorney, plus court costs expended. I hereby give permission to Lakeside North to contact me via the numbers I have provided on issues associated with my account to include cellular numbers connected with me or my account. I hereby consent to treatment.

Patient's Signature: _____ Date: _____

Parent and/or Guardian's Signature _____ Date: _____

***Would you like a copy of our privacy practices? Yes _____ No _____**

Lakeside North

38 Rowe Drive
Guntersville, AL 35976
Phone: (256) 571-8460
Fax: (256) 571-8464

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ **Date of Birth:** _____

Address: _____
City: _____ **State:** _____ **Zip:** _____

SS#: _____ **Phone:** _____

Date of Request: _____ **Type of Records Requested:** _____
****Please send Medical Records Upon Request****

I authorize Lakeside North to **RELEASE or RECEIVE (circle one)** information to/from:

_____
Name of Provider/Facility

_____
Address

_____
City, State, Zip

_____
Phone/Fax Number

I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL INFORMATION. INCLUDING DIAGNOSIS, TREATMENT, PROGNOSIS, ETC. OF THE INJURIES AND/OR ILLNESS RECEIVED BY THE ABOVE NAME PERSON ON AND SUBSEQUENT TO THE DATE OF THE INJURIES AND/OR ILLNESS. AUTHORIZATION IS KEPT ON FILE UNLESS REVOKED IN WRITING.

_____ _____
Signature of Patient/Legal Guardian Date

Name: _____ Today's date: ____/____/_____

Date of Birth: ____/____/_____

I understand that I am required to return to the clinic in 21 days from today's date to receive the 2nd COVID-19 vaccination. If you fail to receive the second vaccination, you will not have the expected immunity from the vaccine series.

It takes time for your body to build protection after any vaccination. COVID-19 vaccines that require 2 shots may not protect you until a week or two after your second shot. You are still susceptible to catching COVID-19 if you are exposed within the two week window after your final vaccination.

I am required to wait 15 minutes for monitoring after vaccination before I leave the facility.

_____

Patient signature

I certify that I am: (a) at least 18 years of age (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine. I understand that the health data shared within this questionnaire will be used to determine my eligibility for receiving the COVID-19 vaccination and further determine timing of when the vaccine will be made available to me. I have been made aware of VIS forms available on our website (www.lakesidenorth.com) to access full vaccination information.

_____

Patient signature