COVID-19 Vaccination Screening Questionnaire

Lark Drugs Pharmacy

Name: _____ Signature: _____

1. **Who is your primary care provider (PCP) _____**

Y / N 2. **Are you feeling sick today?**

Y / N 3. **Have you ever received a dose of COVID-19 vaccine?**

Y / N 4. **Have you received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CART-cell therapies?**

Y / N 5. **Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised?**

Y / N 6. **Have you ever had an allergic reaction to a component of a COVID-19 vaccine or a previous dose of a COVID-19 vaccine?**

Y / N 7. **Have you ever had an allergic reaction to another vaccine (other than a COVID-19 vaccine) or an injectable medication?**

Y / N 8. **Do you have a history of myocarditis or pericarditis?**

Y / N 9. **Do you have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?**

Y / N 10. **Do you have a history of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)?**

Y / N 11. **Do you have a history of Guillain-Barré Syndrome (GBS)?**

Y / N 12. **Do you have a history of COVID-19 disease within the past 3 months?**

Y / N 13. **Have you been vaccinated with MPox vaccine in the last 4 weeks?**

Y / N 14. **Are you pregnant or breastfeeding?**

******************************OFFICE USE ONLY***************************************

☐ Left ☐ Right

Pfizer Lot # _____ Exp. Date _____

☐ CAIR ☐ PCP

RPh Sig: _____ Date _____