COVID-19 Vaccination Screening Questionnaire

Lark Rexall Drugs, Inc. 16251 Main Street, Guerneville, CA 95446 (707) 869-9055

1. Are you feeling sick today?

Yes No

2. Have you ever received a dose of COVID-19 vaccine?

Yes No

3. Which vaccine brand did you receive?

Pfizer-BioNTech Moderna Janssen (J&J) Other _____

4. How many doses of COVID-19 vaccine were administered? _____

5. Did you bring your vaccination record card or other documentation?

Yes No

6. Have you received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?

Yes No

7. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised?

Yes No

Allergic reactions include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused the patient to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.

8. Have you ever had an allergic reaction to a component of a COVID-19 vaccine or a previous dose of a COVID-19 vaccine?

Yes No

9. Have you ever had an allergic reaction to another vaccine (other than a COVID-19 vaccine) or an injectable medication?

Yes No

10. Do you have a history of myocarditis or pericarditis?

Yes No

11. Do you have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?

Yes No

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

Yes No

13. Do you have a history of thrombosis with thrombocytopenia syndrome (TTS)?

Yes No

14. Do you have a history of Guillain-Barré Syndrome (GBS)?

Yes No

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15. Do you have a history of COVID-19 disease within the past 3 months?

Yes No

16. Have you been vaccinated with mpox vaccine in the last 4 weeks?

Yes No

17. Are you pregnant or breastfeeding?

Yes No

Vaccination Consent
Disclosure Statement
Life threatening allergic reactions to vaccines are very rare. Signs of a serious allergic reaction include: shortness of breath, hoarseness of wheezing, hives, paleness, weakness, elevated heart rate, or severe dizziness. These symptoms may occur within a few minutes, or up to 48 hours after the vaccination. If you are experiencing any of these symptoms, you should contact a healthcare provider immediately.

☐ * Written/Verbal Consent: The patient or legal guardian has been provided the benefits and potential adverse reactions, and provides consent to receive the vaccine.

☐ * The patient understands that all immunizations will be reported to the California Immunization Registry (CAIR2/RIDE). The information in the patient's immunization record will be shared with the local health department and California Department of Public Health, shall be treated as confidential medical information, and shall be used only as allowed by the law. The patient may refuse to allow the information to be further shared and can request the record be locked by visiting the Request to Lock My CAIR Record web form.

Name: _____ Date: _____

Date of Birth: _____ Gender: _____

Mother's First Name: _____ (Required)

Are you of Hispanic, Latino or Spanish Origin? (Please specify) _____

Race/Nationality: _____

Email: _____

Phone #: _____ (Required)

Address: _____ (Required)

Health Insurance Carrier (or "none): _____

Insurance ID #_____Medicare ID #_____

Signature: _____

**********Office Use Only**********

☐ Left ☐ Right ☐ Moderna lot#_____ ☐ Pfizer lot# _____