

Prevaccination Checklist for COVID-19 Vaccines



For vaccine recipients:

Patient Name _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.

Age _____

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? | | | |
| <ul style="list-style-type: none"> If yes, which vaccine product did you receive? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Another product _____ | | | |
| 3. Have you ever had an allergic reaction to: <small>(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.)</small> | | | |
| <ul style="list-style-type: none"> A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures | | | |
| <ul style="list-style-type: none"> Polysorbate | | | |
| <ul style="list-style-type: none"> A previous dose of COVID-19 vaccine | | | |
| 4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? <small>(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.)</small> | | | |
| 5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, 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? | | | |

Form reviewed by _____

Date _____