Prevaccination Checklist for COVID-19 Vaccines

CDC

For vaccine recipients:

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 ________			
• Did you bring your vaccination record card or other documentation? *(yes/no)*	☐	☐	
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 caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following:			
○ 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	☐	☐	☐
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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer)
- ☐ Take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of herparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers

Form reviewed by ______________________ **Date** ____________

Name: ______________________________ Date of Birth: ______________

Vaccines for Children (VFC) eligibility - Select if statement is true:

- ○ Patient is 19 years or younger
- ○ Patient is American Indian/Alaska Native
- ○ Patient is uninsured
- ○ Patient has insurance that does not cover vaccines
- ○ Patient is enrolled in CHIP

Consent: I understand the benefits and risks of the vaccine being given today, and ask that it be given to me or the person listed above for whom I am authorized to make consent.

1. I verify that I have been offered and have read (or had read to me) (1) the Emergency Use Authorization Fact Sheet for the COVID-19 Vaccine; (2) this COVID-19 Vaccine Consent Form for the Vaccine; and (3) any additional information provided to me concerning COVID-19 vaccination.
2. I acknowledge that I have had a chance to ask a medical professional questions about the COVID-19 Vaccine.
3. I understand that the Moderna Vaccine will be given in two separate doses four weeks apart, or the Pfizer-BioNTech Vaccine will be given in two separate doses 3 weeks apart.
4. I understand the known risks and the potential benefits of receiving the Moderna or Pfizer BioNTech Vaccine, and I understand there may be risks to the Moderna or Pfizer-BioNTech Vaccine that are not known at this time.
5. I understand that the FDA has authorized use of the Moderna and Pfizer-BioNTech Vaccines under an Emergency Use Authorization (EUA) and that there is currently not enough scientific evidence available for the FDA to fully approve this or any other COVID-19 vaccine.
6. I nonetheless request and consent to the Moderna or Pfizer-BioNTech COVID-19 Vaccine being given to me or my minor child. I attest that the minor receiving the vaccine is age 12 or above.
7. I understand it is recommended that I remain on site for at least 15 minutes after receiving the COVID-19 Vaccine and that, depending on the recommendations of medical professionals, I may be asked to remain on site longer for monitoring.
8. **I understand that receiving the vaccine at this location does not create a physician-patient relationship with any of the providers at Creekside Medical.**
9. I understand if I have concerns or questions after receiving the COVID-19 vaccine I need to call my own PCP or go to an Urgent Care. I acknowledge I will call 911 for a medical emergency.

Signature: ______________________________ Date: ______________

Relationship to Minor: ______________________

Administrative Use Only		
Print Name:	Date & Time:	
If yes answers, form reviewed by:		
Administered by:		
Immunization Given Today	Place label here:	Left Deltoid: ☐ Right Deltoid: ☐
Observed By:		
Waited for (please select one):	○ 15 minutes ○ 30 minutes	
Observation Findings (please select one):	○ No reaction ○ Reaction, please explain:	
Entered in eCW ☐		