PREVACCINATION CHECKLIST FOR COVID-19 VACCINES

Patient Name: _____ DOB: _____ Age: _____

FOR VACCINE RECIPIENTS:

The following questions 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.

	YES	NO	DON'T KNOW
1. Are you feeling sick today?	☐	☐	☐
2. Have you received a dose of the COVID-19 vaccine? If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product	☐	☐	☐
▪ Have you received a complete COVID-19 series (2 doses of Pfizer or Moderna or 1 dose Janssen)?	☐	☐	
▪ Did you bring your vaccination record card or other documentation?	☐	☐	

3. Have you ever had an allergic reaction to: *This includes a severe allergic reaction [e.g., anaphylaxis] that required treatment w/epinephrine or EpiPen® or caused you to go to the hospital. It also includes an allergic reaction causing hives, swelling, respiratory distress, including wheezing.*	YES	NO	DON'T KNOW
▪ **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 includes a severe allergic reaction [e.g., anaphylaxis] that required treatment w/epinephrine or EpiPen® or caused you to go to the hospital. It also includes an allergic reaction causing hives, swelling, respiratory distress, including wheezing.*	☐	☐	☐

5. Check all that apply to you:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed w/Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré Syndrome (GBS)

ANNUAL FLU VACCINE			
	Is your child due for their annual Flu Vaccine?	☐ YES	☐ NO
	If so, **would you like your child to receive their Flu Vaccine today**?	☐ YES	☐ NO

_____ _____

Name of Parent/Legal Guardian

Signature of Parent/Legal Guardian (required for under age 18)

_____ _____

Relationship to Patient

Today's Date

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklist