

Prevaccination Checklist for COVID-19 Vaccines



For vaccine recipients:

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.

Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another Product _____ Did you bring your vaccination record card or other documentation? (yes/no) 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had an allergic reaction to: <i>(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.)</i> <ul style="list-style-type: none"> A component of a COVID-19 vaccine, including either of the following: <ul style="list-style-type: none"> 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 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had an allergic reaction to another vaccine (<i>other than COVID-19 vaccine</i>) or an injectable medication? <i>(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.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Check all that apply to you: <ul style="list-style-type: none"> <input type="checkbox"/> Am a female between ages 18 and 49 years old <input type="checkbox"/> Am a male between ages 12 and 29 years old <input type="checkbox"/> Have a history of myocarditis or pericarditis <input type="checkbox"/> Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies <input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum <input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection <input type="checkbox"/> Have a weakened immune system (i.e., HIV infection, cancer) <input type="checkbox"/> Take immunosuppressive drugs or therapies <input type="checkbox"/> Have a bleeding disorder <input type="checkbox"/> Take a blood thinner <input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT) <input type="checkbox"/> Am currently pregnant or breastfeeding <input type="checkbox"/> Have received dermal fillers 			

Form reviewed by _____

Date _____