FIGHT COVID-19 | GET VACCINATED

COVID VACCINE PRE-SCREENING FORM

Please complete the following questionnaire prior to receiving your vaccine.

	Yes	No
1. Are you feeling sick or do you have a fever today?		
2. Have you had COVID in the last 90 days?		
3. Have you previously received a COVID-19 vaccine?		
4. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?		
a. Was the severe allergic reaction after receiving a COVID-19 vaccine?		
b. Was the severe allergic reaction after receiving another vaccine or another injectable medication?		
5. Have you had a severe allergic reaction to any component or ingredient of the COVID-19 vaccine? Note: The Pfizer-BioNTech COVID-19 Vaccine includes the following ingredients: mRNA, lipids ((4-hydroxybutyl) azanediyl)bis(hexane6,1-diyl)bis(2-hexyldecanoate)), 2[polyethylene glycol) – 2000] –N,N-ditetradecylacetamide, 1,2,-Distearoyl-sn-glycero-3-phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose]		
6. Do you have a bleeding disorder or are you taking a blood thinner?		
7. Have you received monoclonal antibodies or received convalescent plasma for COVID-19?		
8. Are you immunocompromised (have a weakened immune system such as cancer, leukemia, HIV/AIDS, or any other immune system problem) or are you taking medication that affects your immune system?		
9. Are you pregnant or could become pregnant in the next several weeks?		
10. Are you breastfeeding (nursing)?		

If you have answered Yes to any of the above questions, please speak to a nurse before receiving the vaccine. Patients who have had any type of allergic reactions in the past will require 30 minutes of observation after the vaccine.

I have received the EUA Fact Sheet for the Pfizer BioNTech COVID-19 vaccine.
I have had an opportunity to ask questions and any questions have been answered to my satisfaction.

Print Name___________________________________ Date of Birth ____________________

Address________________________________ Contact Number______________________

Email Address _________________________

If not Queens Employed, Company or Employer___________________________

Employee ID (only if Queens Employed) ___________________________

Signature_______________________________________ Date____________________

FOR CLINIC USE ONLY

Dose ____1 ____2

VAMS completed _____

Form 1/22/21