COVID VACCINE PRE-SCREENING FORM

For Pfizer BioNTech COVID-19

Please complete the following questionnaire prior to receiving your vaccine.

	Yes	No	Don't Know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
a If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product _____			
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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
a A component of a COVID-19 vaccine including either of the following:	Yes	No	Don't Know
i Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
ii Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.	☐	☐	☐
b A previous dose of COVID-19 vaccine.	☐	☐	☐
c A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.	☐	☐	☐
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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, 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?	☐	☐	☐
12. Do you have dermal fillers?	☐	☐	☐

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 _____

Company or **Employer**_____

Employee ID (only if Queens Employed) _____

Patient's Signature_____ Date_____

Parent/legal guardian signature (for 17 y/o and below)_____

FOR CLINIC USE ONLY

Dose ____1 ____2

VAMS completed _____