

## COVID-19 Vaccine Pre-Screening Form

Please complete the following questionnaire prior to receiving your vaccine.

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
1. Are you feeling sick or do you have a fever today?	_____	_____
2. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product did you receive? Pfizer/Comirnaty      Moderna      Another product _____	_____	_____
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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)</i>		
• A component of the 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? <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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)</i>	_____	_____
5. Check all that apply to you:		
<input type="checkbox"/> Am a female between ages 18 and 49 years old		
<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 caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
<input type="checkbox"/> Do you have a bleeding disorder or are you taking a blood thinner?		
<input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT)		
<input type="checkbox"/> Are you pregnant or breastfeeding (nursing)?		
<input type="checkbox"/> Have received dermal fillers		

If you checked any of the boxes above, 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 Fact Sheet for the COVID-19 Vaccine that I am receiving.  
I have had an opportunity to ask questions and any questions have been answered to my satisfaction.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian Signature  
if applicable or under age 18 years: \_\_\_\_\_ Print name \_\_\_\_\_