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:

(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 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?	_____	_____

(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. Check all that apply to you:

- ❑ Am a female between ages 18 and 49 years old
- ❑ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ❑ Had tested positive for COVID-19 in the past 20 days
- ❑ Had COVID-19 and/or was treated with monoclonal antibodies or convalescent serum?
- ❑ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ❑ Have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?
- ❑ Do you have a bleeding disorder or are you taking a blood thinner?
- ❑ Have a history of heparin-induced thrombocytopenia (HIT)
- ❑ Are you pregnant or breastfeeding (nursing)?
- ❑ 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/Legal Guardian Signature
if applicable or under age 18 years: _____ Print name_____