FIGHT COVID-19 | GET VACCINATED

THE QUEEN'S HEALTH SYSTEMS

COVID-19 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 ever received a dose of COVID-19 vaccine?	_____	_____

If yes, which vaccine product did you receive?

Pediatric Pfizer 5-11 yrs	Pfizer / Comirnaty 12 yrs +	Moderna (full) 18 yrs +	Moderna (half) 18 yrs +	Janssen (J&J) 18 yrs +
10 mcg/0.2 mL	**30 mcg/0.3 mL**	**100 mcg/0.5 mL**	**50 mcg/0.25 mL**	**0.5 mL**
❑ 1st Dose ❑ 2nd Dose ❑ 3rd Dose (28 days from 2nd dose)	❑ 1st Dose ❑ 2nd Dose ❑ 3rd Dose (28 days from 2nd dose) ❑ Booster (5 months from 2nd dose)	❑ 1st Dose ❑ 2nd Dose ❑ 3rd Dose (28 days from 2nd dose)	❑ Booster (5 months from 2nd dose)	❑ 1st Dose ❑ Booster (2 months after 1st dose)

❑ I have received **2 doses** of the **Pfizer BioNTech** or the **Moderna COVID-19 vaccine** primary series and it has been at least **5 months since my last Pfizer** or **Moderna** COVID-19 vaccine dose. I am requesting **Pfizer, Moderna or Janssen as my booster**.

❑ I have received **1 dose** of the **Janssen** (Johnson & Johnson) **COVID-19 vaccine** primary series and it has been **2 months** since my last COVID-19 dose. I am requesting **Pfizer, Moderna or Janssen as my booster.**

❑ I am **moderately or severely immunocompromised** and I have received **2 doses** of the **Pfizer BioNTech** or the **Moderna COVID-19 vaccine** primary series. It has been at least **28 days since my last Pfizer or Moderna** COVID-19 vaccine dose. I am requesting **Pfizer or Moderna as my 3rd dose.**

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.)

	YES	NO
• 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	_____	_____
• Another vaccine (other than COVID-19 vaccine) or an injectable medication?	_____	_____
• Food, pet, venom, environmental or oral medication allergies?	_____	_____

4. Check all that apply to you:

❑ Am a female between ages 18 and 49 years old
❑ Had tested positive for COVID-19 in the past 10 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

We will review this form with you prior to your vaccination to answer all of your questions about any "yes" answer above. Patients who have had some types of allergic reactions in the past may require a 30 minute observation after the vaccine. I have received the Fact Sheet for the COVID-19 Vaccine that I am receiving.

Print Name_____ Signature_____

Date_____ Date of Birth_____ Age _____ Phone _____

Address _____ City_____ State_____ Zip_____

Parent/Legal Guardian Signature if applicable or under age 18 years: _____ Print name_____