

COVID-19 Vaccine Pre-Screening Form

Please complete the following questionnaire prior to receiving your vaccine.

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. Are you moderately or severely immunocompromised?	_____	_____
3. Date of last vaccination/booster? _____		
4. Which vaccine product would you like to receive today?		
<input type="checkbox"/> MODERNA/ SPIKEVAX . . . Primary: 12 yrs + (100mcg/0.5 mL)		
<input type="checkbox"/> MODERNA BIVALENT Booster 18+ years (50mcg/0.5 mL)		
<input type="checkbox"/> PFIZER/COMIRNATY Pediatric: 6 months – 4 years (3mcg/0.2 mL)		
<input type="checkbox"/> PFIZER/COMIRNATY Pediatric: 5-11 years (10mcg/0.2 mL)		
<input type="checkbox"/> PFIZER/COMIRNATY Primary 12+ years (30 mcg/0.3 mL)		
<input type="checkbox"/> PFIZER BIVALENT Booster 12+ years (30 mcg/0.3 mL)		
5. 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	_____	_____
• Another vaccine (other than COVID-19 vaccine) or an injectable medication?	_____	_____
• Food, pet, venom, environmental or oral medication allergies?	_____	_____
6. Check all that apply to you:		
<input type="checkbox"/> Am a female between ages 18 and 49 years old		
<input type="checkbox"/> Had tested positive for COVID-19 in the past 10 days		
<input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection		
<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		

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 _____