Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name ______________________

Age __________

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	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• 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 component of a 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.			
• 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?			

Form reviewed by ______________________ **Date** ______________

MRN/RX:______________________
GRITS ID:______________________

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COVID-19 VACCINE CONSENT & ADMINISTRATION FORM

NAME:	MOTHER'S MAIDEN NAME:	BIRTHDATE (MM/DD/YY):	
ADDRESS:	CITY:	STATE:	ZIP:
PHONE:	EMAIL:		
ALLERGIES:		GENDER:	

Ethnicity:
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race:
☐ American Indian or Alaskan Native ☐ Asian
☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic or Latino
☐ White ☐ Black or African American

Eligibility:

☐ Age 55 or older ☐ Caregiver for 65 or older ☐ Long Term Care staff and residents

☐ Healthcare Personnel ☐ Law Enforcement, Fire Personnel, First Responders

☐ Educators and Staff ☐ Individual with disabilities

☐ Caregiver for Adult with intellectual/developmental disability ☐ Parent of child with complex medical conditions

☐ Aged 16 and older with medical conditions that increases risk of severe illness from COVID-19

I consent to receive the COVID-19 Vaccine and am eligible per phase designation notated above. I have received the following: the COVID Vaccine EUA Fact Sheet for recipients and caregivers, the pre-vaccination Checklist for COVID-19 Vaccines, the V-SAFE flyer and have been informed on how to register for the after-vaccination health checker.

Signature of Patient:____Signature of Person administering Vaccine;________________________________

INTERNAL USE ONLY:

Vaccine: Pfizer Moderna	**Route/Site: IM Left Arm IM Right Arm**	**Dose: 1st 2nd**
DATE/TIME:	**LOT:**	**EXP:**
VACCINE ADMINISTRATOR:		