

Prevaccination Checklist for COVID-19 Vaccines



For vaccine recipients:

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.

Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever received a dose of COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> If yes, which vaccine product did you receive? <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another Product _____ Have you received a complete COVID-19 vaccine series (i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna])? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you bring your vaccination record card or other documentation? <input type="checkbox"/> Yes <input type="checkbox"/> No 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 caused hives, swelling, or respiratory distress, including wheezing.)</i>			
<ul style="list-style-type: none"> A component of a COVID-19 vaccine, including either of the following: <ul style="list-style-type: none"> Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know A previous dose of COVID-19 vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<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 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"/> Am a male between ages 12 and 29 years old			
<input type="checkbox"/> Have a history of myocarditis or pericarditis			
<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 bleeding disorder			
<input type="checkbox"/> Take a blood thinner			
<input type="checkbox"/> Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies			
<input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT)			
<input type="checkbox"/> Am currently pregnant or breastfeeding			
<input type="checkbox"/> Have received dermal fillers			
<input type="checkbox"/> History of Guillain-Barré Syndrome (GBS)			

Form reviewed by _____

Date _____

Recipient Name: First _____ Middle _____ Last _____
Date of Birth ____/____/____ **Recipient Email Address:** _____ No email
Home Phone Number: _____ **Mobile Phone Number:** _____
Address: _____ **City:** _____
Zip Code: _____ **County:** _____ **State:** _____
Best way to contact you: SMS/Text Message Email Both None
Recipient Race: American Indian/Alaska Native Asian Black/African American
 Native Hawaiian or Other Pacific Islander White Other Unknown
Recipient Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown
Recipient Gender: Male Female Other I do not want to specify
Preferred Language: English Vietnamese Arabic French
 Spanish Hindi Other Decline to state
Disabilities: Not Disabled Cancer Cognitive (Psychological or Psychiatric)
 Neurological Physical (Mobility) Respiratory
 Sensory (Vision or Hearing) Other (Please Specify: _____)

I certify that I am able to consent for this COVID19 vaccine against this communicable disease or I am the parent or legal guardian of the above named patient if they are a minor. I consent to receive the vaccine and for my demographic and health condition information to be shared with the COVID-19 Management System (CVMS) as required. I have received a copy of the Emergency Use Authorization Fact Sheet on the Pfizer COVID-19 vaccine (QR codes 5-11yo top right). I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction after leaving the office, I will call 911 or go to the nearest hospital. Bottom right QR for V-Safe tool to connect to CDC about your vaccine.



I authorize payment from private Insurance or Medicaid to be made on my behalf to the licensed healthcare provider administering the vaccine for services provided. I understand that my signature below will serve as legal "signature on file" for purposes of filing insurance/Medicaid claims and payment of benefits to Pediatric Partners. **THE COVID VACCINES ARE FREE TO EVERYONE, REGARDLESS OF WHETHER YOU HAVE PRIVATE OR GOVERNMENT INSURANCE OR NO INSURANCE AT ALL.** If you are not an existing Pediatric Partners patient, we need a copy of your insurance card so we can bill your insurance (No out of pocket cost to you by Federal Law.)

Signature _____ Date _____

Print name _____ (Parent/guardian must sign if <16yo)

Site of Injection: Right Deltoid, IM Left Deltoid, IM Other _____ 1st dose 2nd 3rd Booster
Administration Date: ____/____/____ **Time:** _____ Pfizer COVID19 vaccine (COMIRNATY)
Lot #: _____ **Exp:** ____/____/____ **Vaccine administered by:** _____