

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 <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another Product _____ Did you bring your vaccination record card or other documentation? (yes/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 Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids A previous dose of COVID-19 vaccine | <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 weakened immune system (i.e., HIV infection, cancer) | | | |
| <input type="checkbox"/> Take immunosuppressive drugs or therapies | | | |
| <input type="checkbox"/> Have a bleeding disorder | | | |
| <input type="checkbox"/> Take a blood thinner | | | |
| <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 | | | |

Form reviewed by _____

Date _____