Pre-Vaccination Checklist and Questionnaire 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 the pharmacist to explain it.

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____ Phone Number: _____

Race: (Select all that apply)

- O American Indian or Alaska Native
- O Asian
- O Native Hawaiian or Other Pacific Islander
- O Black or African American
- O White
- O Other Race: _____

Ethnicity: (Select one)

- O Hispanic or Latino
- O Not Hispanic or Latino

PARENT/GUARDIAN SIGNATURE REQUIRED (IF UNDER THE AGE OF 18) _____

PLEASE COMPLETE	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? O Pfizer O Moderna O Johnson & Johnson O Other:			
3. Have you ever had a severe allergic reaction to something? For example, a reaction for which you were treated with epinephrine or EpiPen or for which you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

Pharmacy Use Only

Form reviewed by: _____ Date: _____

Time Administered: _____ Uninsured? **Yes** **No**

Manufacturer: _____ Lot: