

Prevaccination Checklist for COVID-19 Vaccines



For vaccine recipients:

Patient Name _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.

Age _____

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

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
<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"/> Another product _____ 			
3. Have you ever had an allergic reaction to:			
<small>(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.)</small>			
<ul style="list-style-type: none"> A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures 			
<ul style="list-style-type: none"> Polysorbate 			
<ul style="list-style-type: none"> A previous dose of COVID-19 vaccine 			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?			
<small>(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.)</small>			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, 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?			

Form reviewed by _____

Date _____

COVID-19 Vaccine Patient Screening/Vaccine Administration Record

Patient Information

Last Name First Name Date of Birth Gender Race/Ethnicity

Address City State Zip

Insurance Information

Please ensure to record both pharmacy and medical insurance information since there are multiple ways that the vaccine administration can be billed at the pharmacy.

Non-Medicare	Pharmacy	Medical	Medicare (Red, White & Blue Card) #
Insurance Plan Name			BRING INSURANCE CARDS OR COPY OF INSURANCE CARDS
Member/Recipient ID			
RX Bin		N/A	
RX PCN		N/A	
Group Number			

Are you the cardholder? (please circle one): YES NO

If no, please provide cardholder's name, date of birth, and relationship:

Cardholder Name	Date of Birth	Relationship to Patient

Patient Consent

I understand the benefits and risks of the vaccination as described in the Emergency Use Authorization (EUA) and/or CDC Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I request the vaccine be given to me or the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release.

Signature of Person to Receive Vaccine (or Parent/Guardian, if a minor):

_____ Date: _____

Print Parent/Guardian name if recipient is a minor: _____ Date: _____

I have received a copy of the notice of Privacy Practices. I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the Pharmacy and my rights with respect to my health information, including reporting to the State Vaccination Registry and/or local or state Departments of Health, federal Department of Health and Human Services, and the Center for Disease Control and Prevention.

Signature of Person to Receive Vaccine (or Parent/Guardian, if a minor):

_____ Date: _____

(Print Parent/Guardian name if recipient is a minor): _____ Date: _____

To be completed by Vaccine Administrator

Vaccine	Date Administered	Vaccine Lot#	Expiration Date	MFR	Dosage	Injection Site	VIS/EUA Date	Dose #1 or #2

Administering Immunizer Signature: _____ Date: _____