Prevaccination Checklist for Vaccines

The following questions will help us determine if there is any reason you should not be vaccinated today. **If you answer "yes" to any of the following questions, it does not necessarily mean you should not be vaccinated.** It just means additional questions might be asked.

Child's age (5-11yrs): _________

RxID:	RxBIN:	RxPCN:	RxGRP:
SS#:	Sex: ☐ Male ☐ Female	Mother's Maiden Name:	
First:	Last:	Date of Birth:	
Address:		Phone#:	
Email Address:			
Race: ☐ American Indian/ Alaska Native ☐ Asian ☐ Black/ African American ☐ Hispanic/ Latino ☐ White ☐ Native Hawaiian/ Other			

Answer **"yes"** or **"no"** to the following questions:	Si	No	Not sure
1. Are you feeling sick today?			
2. Which vaccine are you requesting? ☐ **Pfizer** ☐ **Moderna** ☐ **J&J** ☐ **Other** ___________________			
3. Have you ever had an allergic reaction? (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.)			
4. Have you ever had a severe allergic reaction to something other than a component of any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies? (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 received any vaccine in the last 14 days?			
6. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
8. Do you have a weakened immune system cause by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
9. Do you have a bleeding disorder or are you taking blood thinners?			
10. Do you have a history of or risk factor for blood clotting disorder?			
11. Are you pregnant or breast feeding?			
12. Do you have dermal fillers?			

Form reviewed by: ____ Date: _______________

(Left arm ☐ or Right arm ☐) (Subcutaneous ☐ or Intramuscular ☐) <- **FOR PHARMACY ONLY!**