Pre-Vaccination Checklist for COVID-19 Vaccines

AllHealth Network Pharmacy
5500 S Sycamore St Ste 100
Littleton, CO 80120-8201
Phone: (303) 797-2500 Fax: (303) 730-8730

Name: ______________________ Male: ________ Female: ________ Date of Birth: ______________

Address: ______________________ City: ______________ State: ________ Zip: ________

Phone: ____________ Allergies: ______________________ Race: ______________

Primary Care Physician: ______________________ Office Phone Number: ______________________

Emergency Contact ______________________ Relation: ____________ Phone Number: ____________

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.

1. Are you feeling sick today? — Yes No
2. Have you ever received a dose of COVID-19 vaccine? — Yes No
   - If yes, which vaccine product? Date of first dose?

   ☐ Pfizer, Date: ________ ☐ Moderna, Date: ________ ☐ Another product ______________
3. Have you ever had an allergic reaction to:

   (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 occurered within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)
   - 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 — Yes No
   - Polysorbate — Yes No
   - A previous dose of COVID-19 vaccine — Yes No
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? — Yes No

   (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 occurered within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)
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. — Yes No
6. Have you received any vaccine in the last 14 days? — Yes No
7. Have you ever had a positive test for COVID-19 or has the doctor ever told you that you had COVID-19? — Yes No
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? — Yes No
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppresive drugs or therapies? — Yes No
10. Do you have a bleeding disorder or are you taking a blood thinner? — Yes No
11. Are you pregnant or breastfeeding? — Yes No

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Consent

☐ I understand this vaccine has been authorized for emergency use by U.S. Food & Drug Administration (FDA). An Emergency Use Authorization (EUA) facilitates the ability and use of medical countermeasures, including vaccines, during public health emergencies. I understand this vaccine has not yet been fully approved by the FDA.

☐ I understand there is currently not a Vaccine Information Statement (VIS) for the COVID-19 vaccine since it is currently available through EUA. I have been provided and read the EUA Fact Sheet for Recipients ver 12/20/2020, which may be updated, and the most recent version can be found at www. cvdvaccine.com or www. modernatx.com/covid19vaccine-eua. I had an opportunity to ask questions and for my questions to be answered.

☐ I understand that all the potential side effects from this vaccine may not be fully known at this time.

☐ I understand there may be various health conditions that have not yet been tested in conjuction with this vaccine.

☐ I understand when I receive one dose of the COVID-19 vaccine, I should receive a second dose of this same vaccine within the timeframe specified to complete the vaccination series. The efficacy rate of the vaccine increases significantly after a second dose. If this is my second dose, I will bring my vaccine card with me to be completed.

☐ I agree to receive the COVID-19 vaccine.

☐ I agree to stay in the vaccine administration area for fifteen (15 minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur.

☐ I understand that I will be receiving the vaccination at no cost to me.

☐ If insured, please bring in your prescription and medical insurance cards for your vaccine appointment. I authorize the pharmacy to bill my insurance on my behalf for the immunization -- understanding I will not incur any costs.

If un-insured, you must check the box below to attest that the following information is true and accurate:

☐ I do not have any insurance, including but not limited to, Medicare, Medicaid, or any other private or government-funded benefit plan.

For un-insured patients, please select at least one of the following that you will bring with you to your appointment.

This is needed in order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program.

☐ Social Security Number

☐ State identification number and state of issuance

☐ Driver's license number and state of issuance

Person completing form: ☐ Self ☐ Parent / Legal Guardian

Name (print) ________________________ **Signature** ________________________ **Date** ______________

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ICD 10: __Z23 (Encounter for Immunization)_____

Administration (Pharmacist Use Only)

Vaccine	Dose	Product Name	NDC	Route	Lot	Exp Date	Dose	Site of Injection (circle one)	Date of VIS / EUA	Date VIS / EUA Given to Patient
COVID-19	1st 2nd	Moderna	80777-0273-10	Intramuscular			0.5 ml	LD RD	12/2020	

I have verified the immunization(s) that the patient requested meets state, age and vaccine restrictions. Initial here: _____________

I have verified the requested immunization(s) is the same as the product prepared. Initial here: _____________

I have verified the expiration date of the product is greater than today's date. Initial here: _____________

I have provided counseling and reviewed the purpose and side effects of the vaccines provided. Initial here: _____________

Any adverse reactions? YES / NO If yes, please explain in the Notes section below.

Protocol physician notified by fax/mail/phone on: ___________________

Primary Care physician notified by fax/mail/phone on: ___________________

Immunizer Name (print) ________________________________Immunizer Signature________________________________RPh / PharmD / Intern / CPhT (Circle one)

If Applicable, Supervising Pharmacist Name (print) _____________________________________Administration Date: ___________________________

Notes

Please include a brief summary of what was discussed (i.e., risks/benefits, contraindications, patient questions that were answered, risk factors, etc.) or any adverse reactions observed.