

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
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"/> Janssen (Johnson & Johnson) <input type="checkbox"/> 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
<ul style="list-style-type: none"> A component of a COVID-19 vaccine including either of the following: <ul style="list-style-type: none"> <input type="checkbox"/> Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures <input type="checkbox"/> Polysorbate, which is found in some vaccines, film coated tablets, and intravenous sterolds. A previous dose of COVID-19 vaccine. A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction. 			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?			
(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 ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, 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?			
12. Do you have dermal fillers?			

Form reviewed by _____

Date _____



PLAZA PHARMACY
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 TEL (310) 530-3010 FAX (310) 530-7618

TEMPERATURE _____ °C

PATIENT INFORMATION

Last Name (성) _____ First Name (이름) _____

Date of Birth (생년월일) ____/____/____ TEL _____

Address (주소) _____
 CITY STATE ZIP CODE

Social Security Number _____ Driver's License Number _____

Ethnicity (민족) _____

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 am authorized to sign this Consent and Release.

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	LOT#	Exp. Date	MFR	Dosage	Injection Site	VIS/EUA Date	Dose 1 st or 2 nd
						L DEL R DEL		

Administering Immunizer Signature: _____ Date: _____

Medicare	Medical	Non-Medicare/Private		HRSA	
Medical Code:	Medical Code: None	BIN		BIN	
Incentive: \$40.00	Clarification Code:	PCN		PCN	
	Incentive: \$0	ID		ID	
	DUR: None	GROUP		GROUP	