

Facility Name _____

Patient Name _____

Age _____

DOB _____

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 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: (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 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? (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, 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 or considering becoming pregnant in the next month?			
12. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barre syndrome (a condition that causes paralysis) or other nervous system problem?			

Patient, Guardian, or LTCF Representative Signature: _____

For Pharmacy Use Only: Date Vaccinated: _____ Vaccine: _____ Site of Admin: _____

Mfr: _____ Lot #: _____ Exp Date: _____

Vaccine Administered by: _____