Screening Checklist for Contraindications to Vaccines for Adults

Peopless Pharmacy LLC

Last Name *(Please print)*	First Name	MI	Date of Birth	☐ Male ☐ Female ☐ Other
Address		City	State	Zip
Phone Number	Email			

CIRCLE PREFERENCE: MODERNA | P F I Z E R | JANSSEN | NOVAVAX

CIRCLE One: Booster Dose | Primary Dose

The vaccine that will be administered may not be your preferred vaccine. This depends on the availability at our pharmacy!

Do you have insurance? ☐ No ☐Yes

NOTE: If you have MEDICARE- RED & BLUE CARD please put it in primary insurance

Primary Insurance: **Subscriber's Name:** **Date of birth:**

Group NO : **RX PCN:** **Member ID#:** **RX BIN:** **Client's relationship to subscriber:**

The above information is true to the best of my knowledge. If qualified, I authorize billing to my insurance company and release of information required to process my claims. I authorize my insurance benefits to be paid directly to Peoples Pharmacy LLC.

For uninsured patients, please select at least one of the following to bring with you to your appointment

☐ Social Security ☐State identification number and state of issuance ☐ Driver's license number and state of issuance

SCREENING FOR VACCINATION ELIGIBILITY

1. Are you sick today?	Yes	No
2. Do you have allergies to medications, food, a vaccine component, or latex?	Yes	No
3. Have you ever had a serious reaction after receiving a vaccination?	Yes	No
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	Yes	No
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes	No
6. Do you have a parent, brother, or sister with an immune system problem?	Yes	No
7. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid	Yes	No
8. arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	Yes	No
9. Have you had a seizure or a brain or other nervous system problem?	Yes	No
10. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes	No
11. For women: Are you pregnant or is there a chance you could become pregnant during the next month?		
12. Have you received any vaccinations in the past 4 weeks?	Yes	No
14. Did you bring your immunization record card with you? *It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it*	Yes □	No □

CONSENT FOR VACCINATION

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS) provided to me today. I understand the benefits and risks of the vaccine. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

By signing this form, I give permission for a vaccine to be administered to the person above and a record of the vaccination to be entered into the **Virginia Immunization Information System** (VIIS) for care coordination and to monitor statewide vaccination coverage. For more information about VIIS, please go to https://www.vdh.virginia.gov/immunization/viis/. Further, I agree that the information above is correct.

Signature of Parent/Guardian/Patient _____ _____**Date**

Screening Checklist for Contraindications to Vaccines for Adults

Peopless Pharmacy LLC

FOR ADMINISTRATIVEUSE ONLY	**EUA or VIS Date:**

Vaccine	Date Vaccination and EUA/VIS Given:	Route IM *R L*	Manufacturer	Lot No.	Printed Name and Signature of Vaccine Administrator

INFORMATION FOR HEALTH CARE PROFESSIONALS ABOUT VACCINATION ELIGIBILITY

1. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to a vaccine or injectable therapy, or a history of anaphylaxis due to any cause?
   IF YES: Please ask the patient whether they discussed vaccination with a medical provider. If they have, allow vaccination to proceed. Vaccine providers should observe patients after vaccination to monitor for the occurrence of immediate adverse reactions:
   - **Persons with a history of anaphylaxis: 30 minutes**
   - **All other persons: 15 minutes**

2. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of the vaccine, including lipid nanoparticles or polyethylene glycol (PEG)? **IF YES: Do Not Vaccinate**

3. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?
   IF YES: Do Not Vaccinate

4. Are you under age 5?
   FOR PFIZER VACCINE, IF YES: Do Not Vaccinate
   FOR MODERNA OR JOHNSON & JOHNSON VACCINE, IF UNDER AGE 18: Do Not Vaccinate

5. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?
   IF YES: Have patient discuss existing symptoms with a medical provider.

6. Do you have a bleeding disorder or are you taking a blood thinner?
   IF YES: Have patient discuss with a medical provider. ACIP recommends the following technique for intramuscular vaccination in patients with bleeding disorders or taking blood thinners: a fine-gauge needle (23-gauge or smaller caliber) should be used for the vaccination, followed by firm pressure on the site, without rubbing, for at least 2 minutes.

7. Have you tested positive for COVID-19 in the last 10 days? **IF YES: Do Not Vaccinate**

8. Are you currently in quarantine for COVID-19 exposure? **IF YES: Do Not Vaccinate**

9. If this is your second dose, when was the date of your first dose?

Screening Checklist for Contraindications to Vaccines for Adults

Peopless Pharmacy LLC

Do Not

Vaccinate if less than 17 days ago for Pfizer, or less than 24 days ago for Moderna.

10. Have you been diagnosed with Multisystem Inflammatory Syndrome in adults or children in the last 90 days?
    IF Yes: Have patient discuss with a medical provider.

11. Have you ever been diagnosed with myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the outer lining of the heart)?
    IF YES: Have patient discuss with their clinical team, which may include a cardiologist.

12. If this is your second dose, which vaccine did you receive (Pfizer, Moderna, etc.)?
    Ensure that the second dose is from the same manufacturer as the first dose. **If different: Do Not Vaccinate.**

    NOTE: Third doses and booster doses: CDC recommends people with moderately to severely weakened immune systems receive a third dose of either Pfizer-BioNTech or Moderna COVID-19 vaccine at least 28 days after they got their second COVID-19 dose.

    CDC has authorized booster doses of Pfizer-BioNTech for certain populations. If you have any questions about your individual risk for COVID-19 or underlying medical condition, please consult your healthcare provider.

13. Do you have a moderately to severely compromised immune system?
    If yes, patient is eligible for a third dose.

14. If this is your third dose, when was your second dose?
    Ensure that the third dose is 28 days after the second dose.

15. If this is your third dose, which vaccine did you receive (Pfizer, Moderna,.)?
    Ensure that the third dose is from the same manufacturer as the first and second dose.

16. If this is a booster dose, when was the date of your second dose of the Moderna or Pfizer-BioNTech COVID-19 vaccines or the date of your first dose of the Janssen (J/J) vaccine?
    Ensure individuals who received Moderna or Pfizer for their initial vaccine series is 6 months past the date of their 2nd dose to receive a booster, ensure individuals who received Janssen (J/J) are 2 months past their initial dose to receive a booster.