

COVID-19 Vaccine Screening Form

Name: _____ Date of Birth: _____ Age: _____ Gender: M / F

Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____

Allergies: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown Prefer not to answer

Race: American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander

Black or African American White Other Prefer not to answer

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 pharmacist 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"/> Novavax <input type="checkbox"/> Another Product: _____ • If yes, what are you looking for today? <input type="checkbox"/> A dose of Pfizer-BioNTech monovalent vaccine to complete primary series. <input type="checkbox"/> A dose of Pfizer-BioNTech bivalent vaccine as a booster. 			
3. Did you bring your vaccination record card or other documentation?			
4. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? <i>This would include, but not limited to, treatment for cancer, HIV, recipient of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant, or moderate or severe primary immunodeficiency.</i>			
5. Have you ever received a COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?			
6. Have you ever had an allergic reaction* to a component of the COVID-19 vaccine?			
7. Have you ever had an allergic reaction* to a previous dose of COVID-19 vaccine?			
8. Have you ever had an allergic reaction* to another vaccine (other than COVID-19) or an injectable medication?			
9. Check all that apply to you: <ul style="list-style-type: none"> <input type="checkbox"/> Have a history of myocarditis or pericarditis <input type="checkbox"/> Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A) <input type="checkbox"/> Have a history of immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT) <input type="checkbox"/> Have a history of thrombosis with thrombocytopenia syndrome (TTS) <input type="checkbox"/> History of Guillain-Barre Syndrome (GBS) <input type="checkbox"/> Have a history of COVID-19 disease within the past 3 months 			

*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 caused hives, swelling, or respiratory distress, including wheezing.

I reviewed the current federal Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers and understand the contraindications, precautions and possible side effects of the vaccine.

Patient/Parent or Guardian Signature: _____ Date: _____

FOR PHARMACY USE ONLY **

Add pharmacy prescription label here

Manufac. & dose: Pfizer 0.3ml

Deltoid IM: Right / Left

Lot: _____ Exp: _____

Given By: _____

MSU Student

MCIR completed