

COVID-19 Vaccine Screening Form

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

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

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"/> Another Product: _____ • Did you bring your vaccination record card or other documentation? (yes/no) 			
3. Have you ever had an allergic reaction* to:			
<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 • Polysorbate, which is found in some vaccines, film coated tablets, and IV steroids • A previous dose of COVID-19 vaccine 			
4. Have you ever had an allergic reaction* to another vaccine (other than COVID-19) or an injectable medication?			
5. Check all that apply to you: <ul style="list-style-type: none"> <input type="checkbox"/> Am a female between ages 18 and 49 years old <input type="checkbox"/> Am a male between ages 12 and 29 years old <input type="checkbox"/> Am 65 years or older or reside in a long term care facility <input type="checkbox"/> Am between the ages of 18-64 years old and have an underlying medical condition as outlined by the CDC <input type="checkbox"/> Am between the ages of 18-64 years old and am at increased risk for COVID-19 exposure and transmission because of occupational or institutional setting <input type="checkbox"/> Have a history of myocarditis or pancreatitis <input type="checkbox"/> Had a severe allergic reaction (e.g. anaphylaxis) to something other than a vaccine injectable therapy such as food, pet, venom, environmental, or oral medication allergies <input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum <input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection <input type="checkbox"/> Have a weakened immune system (i.e. HIV infection, cancer) or take immunosuppressive drugs or therapies <input type="checkbox"/> Have a bleeding disorder <input type="checkbox"/> Take a blood thinner <input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT) <input type="checkbox"/> Am currently pregnant or breastfeeding <input type="checkbox"/> Have dermal fillers <input type="checkbox"/> History of Guillain-Barre Syndrome (GBS) 			

*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