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?			
• If yes, what was the date of your last vaccination? _____ • If yes, was the last dose received a bivalent vaccine? ☐ Yes ☐ No ☐ Don't know (Note: to receive an additional bivalent dose, must be ≥ 65 years old or immunocompromised)			
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? *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.*			
5. Have you ever received a hematopoietic cell transplant (HCT) or CAR-T-cell therapies? (If yes, please let Pharmacist know if you received a COVID-19 vaccine before or during treatment.)			
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: ☐ Have a history of myocarditis or pericarditis ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A) ☐ Have a history of immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT) ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS) ☐ History of Guillain-Barre Syndrome (GBS) ☐ 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.

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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