MSU Health Care
PHARMACY

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?			
If yes, which vaccine product did you receive? Pfizer Moderna Janssen Another Product:			
3. Have you ever had an allergic reaction* to:			
• 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			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction			
4. Have you ever had an allergic reaction* to another vaccine (other than COVID-19) or an injectable medication?			
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 had a positive test for COVID-19 or has a doctor told you that you had COVID-19 in the past 90 days?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 in the past 90 days?			
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?			
12. Do you have dermal fillers?			

*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.

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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: _____

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Manufac. & dose: Pfizer 0.3ml Deltoid IM: Right / Left Lot: _____ Exp: _____

Given By: _____

☐ MSU Student ☐ MCIR completed