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 (Johnson & Johnson) ☐Another Product: _____ • Did you bring your vaccination record card or other documentation? (yes/no)			
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			
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:

☐ Am a female between ages 18 and 49 years old

☐ Am a male between ages 12 and 29 years old

☐ Am 18 years of age or older needing a booster dose (received Pfizer, Moderna, or other WHO approved vaccine for primary series)

☐ Am 18 years of age or older needing a booster dose (received Johnson & Johnson for primary series)

☐ Have a history of myocarditis or pancreatitis

☐ 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

☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum

☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection

☐ Have a weakened immune system (i.e. HIV infection, cancer) or take immunosuppressive drugs or therapies

☐ Have a bleeding disorder

☐ Take a blood thinner

☐ Have a history of heparin-induced thrombocytopenia (HIT)

☐ Am currently pregnant or breastfeeding

☐ Have dermal fillers

☐ 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.

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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