

Prevaccination Checklist for COVID-19 Vaccination



For vaccine recipients:

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 healthcare provider to explain it.

Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever received a dose of COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> If yes, which vaccine product(s) did you receive? <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another Product _____ How many doses of COVID-19 vaccine have you received? _____ Did you bring your vaccination record card or other documentation? <input type="checkbox"/> Yes <input type="checkbox"/> No 			
3. Check all that apply:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> I live in a long-term care setting.			
<input type="checkbox"/> I have been diagnosed with a medical condition(s). Please list: _____			
<input type="checkbox"/> I am a first responder.			
<input type="checkbox"/> I work in a long-term care facility, correctional facility, hospital, restaurant, retail setting, school, or other setting with high exposure to the public.			
4. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? <i>(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematocrit therapy [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had an allergic reaction to: <i>(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>			
<ul style="list-style-type: none"> A component of a COVID-19 vaccine, including either of the following: <ul style="list-style-type: none"> <input type="checkbox"/> Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures <input type="checkbox"/> Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids A previous dose of COVID-19 vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know 			

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Yes No Don't know

7. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?

(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.)

8. 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
- Have a history of myocarditis or pericarditis
- Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19
- Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- Have a bleeding disorder
- Take a blood thinner
- Have a history of heparin-induced thrombocytopenia (HIT)
- Am currently pregnant or breastfeeding
- Have received dermal fillers
- Have a history of Guillain-Barré Syndrome (GBS)

Form reviewed by _____

Date _____