

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.

Patient Name: _____

DOB: _____ Age: _____

1. Are you feeling sick today?

Yes	No	Don't know
<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"/>
--------------------------	--------------------------	--------------------------

• If yes, which vaccine product(s) did you receive?

- Pfizer-BioNTech
 Moderna
 Janssen (Johnson & Johnson)
 Another Product _____

• How many doses of COVID-19 vaccine have you received? _____

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Did you bring your vaccination record card or other documentation?

3. Check all that apply:

I live in a long-term care setting.

I have been diagnosed with a medical condition(s). Please list: _____

I am a first responder.

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? *(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)*

<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: *(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.)*

• A component of a COVID-19 vaccine, including either of the following:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

• A previous dose of COVID-19 vaccine

Prevaccination Checklist for COVID-19 Vaccination



Yes No Don't know

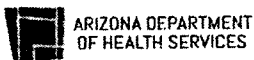
7. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?

(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 (office use only): _____ Date: _____



Parent or Guardian or Vaccine Recipient - Please read and initial:

Initial HERE	
	<u>Statement 1:</u> I have read or have had explained to me the information contained in the Vaccine Information Fact Sheet for the COVID-19 vaccine. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on this form be given to me or the person names on this health record for who I am authorized to make this request.
	<u>Statement 2:</u> I agree to allow the health care provider giving vaccinations to release information about all vaccinations given to me, or to the person for whom I am authorized to consent to, to the Arizona State Immunization Information System (ASIS), other health care providers and schools in order to avoid receiving unnecessary vaccinations and to provide information about what immunizations have been received. I understand that I am not required to agree to the release of this information in order to receive the vaccinations I request.

** If I do not wish this record to be included in ASIS, I have the option of crossing out the above boxed statement and initialing it. I understand that by making this decision, I (or my child) will not have access to their immunization records (in ASIS) in the future for schools, college attendance, future jobs/employment, military, etc.

I am authorized and consent to administration of the Pfizer COVID-19 vaccine. I understand there is no guarantee that this vaccine will prevent my child/teen from contracting COVID-19. Desert Shores Pediatrics will bill my insurance for vaccine administration, if applicable, but this is a publicly funded vaccine and is available at no cost.

Signature of Parent/Legal Guardian _____

Date _____