

Prevaccination Checklist for COVID-19 Vaccination



Name _____

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.

	Yes	No	Don't know
1. How old are you? _____			
2. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever received a dose of COVID-19 vaccine? • 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 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? <i>This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	<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>			
• A component of a COVID-19 vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• A previous dose of COVID-19 vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had an allergic reaction to another vaccine (<i>other than COVID-19 vaccine</i>) or an injectable medication? <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>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Check all that apply to you:			
<input type="checkbox"/> Have a history of myocarditis or pericarditis			
<input type="checkbox"/> Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?			
<input type="checkbox"/> History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)			
<input type="checkbox"/> Have a history of thrombosis with thrombocytopenia syndrome (TTS)			
<input type="checkbox"/> Have a history of Guillain-Barré Syndrome (GBS)			
<input type="checkbox"/> Have a history of COVID-19 disease within the past 3 months?			

Form reviewed by _____

Date _____



COVID-19 VACCINE CONSENT FORM

Patient's Name: _____ DOB: _____

Vaccine: COVID-19 Vaccination (Pfizer)



ARIZONA DEPARTMENT
OF HEALTH SERVICES

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

Initials	
	<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