COVID-19 Vaccination Screening Form
Vaccine Recipients Ages 5 and older
MUST BE FULLY COMPLETED

Vaccine Recipient Name (Last, First, MI): _____

If Applicable, parent name (Last, First, MI): _____

Address: _____ Town: _____State: ____ Zip: _____

Phone Number: _____ Email address: _____

Date of Birth (MM/DD/YYYY): _____

Gender:
- ☐ Male
- ☐ Female
- ☐ Other

Ethnicity:
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Please note any relevant medical conditions that the vaccinator needs to be aware of:

_____

Screening Questionnaire for COVID-19 Vaccine Recipients (please circle your response, Y= Yes N = No):

CS1	Do you have any symptoms of COVID-19 that are new, including: • Fever, chills or feeling feverish; • Respiratory symptoms such as runny nose, nasal congestion, sore throat, cough, or shortness of breath; • General body symptoms such as muscle aches or severe fatigue; • Nausea, vomiting, or diarrhea; or • Changes in your sense of taste or smell?		
CS2	Have you recently tested positive for, or been diagnosed with, active COVID-19 in the prior 10 days (and are supposed to be isolating at home)?		
CS3	Have you been identified as a close contact of someone with COVID-19 in the past 14 days?		
PS1	Have you previously received any doses of a COVID-19 vaccine? If yes: • What vaccine product was used? _____ • What dose is being sought from this clinic? ☐ 1st ☐ 2nd ☐ 3rd ☐ Booster		
PS2	Do you have a preferred product* for today's dose? ☐ Pfizer (12 years & up) ☐ Pfizer (5-11) ☐ Janssen ☐ Moderna ☐ Moderna Booster *for vaccine recipients 5-17 years old, Pfizer is the only product available		

PS3	Have you ever had a severe life-threatening allergic reaction (like anaphylaxis) to any ingredients in the vaccine (which includes polyethylene glycol)? ***OR*** Do you have a known/diagnosed allergy to a specific component of the vaccine?	☐	☐
PS4	Have you ever had an immediate allergic reaction to other vaccines or injectable medications?	☐	☐
PS5	Do you have a history of allergic reaction or allergies to latex, medications, food or vaccines? If yes, please list:	☐	☐
PS6	Do you have a bleeding disorder or are you currently taking a blood thinner?	☐	☐
PS7	Have you received a passive antibody therapy to treat COVID-19 in the previous 90 days or received passive antibody therapy for post-exposure prophylaxis to prevent COVID=19 after an exposure to someone with COVID-19?	☐	☐
PS8	Are you moderately or severely immunocompromised?	☐	☐
PS9	Are you currently pregnant or breastfeeding?	☐	☐
PS10	Do you have a history of an immune-mediated health condition that caused thrombosis (blood clotting) AND thrombocytopenia (low platelet counts), such as "heparin-induced thrombocytopenia" (HIT), which you have recovered from in the last 90 days?	☐	☐
PS11	Are other vaccines being administered with the COVID-19 vaccine?	☐	☐
Answer the following questions only if you have received a prior dose of a COVID-19 vaccine			
PV1	Have you ever had a severe life-threatening allergic reaction (like anaphylaxis) to a prior dose of a COVID-19 vaccine?	☐	☐
PV2	Have you ever had a non-severe, immediate allergic reaction after a previous dose of a COVID-19 vaccine?	☐	☐
PV3	Did you develop myocarditis or pericarditis after receiving an earlier dose of an mRNA COVID-19 vaccine (Pfizer-BioNTech or Moderna)?	☐	☐
PV4	If the vaccine recipient has previously received the Janssen COVID-19 vaccine, has s/he developed Thrombosis with Thrombocytopenia Syndrome (TTS) or Guillain-Barre syndrome (GBS) after receiving the vaccine?	☐	☐

VACCINE ADMINISTRATION RECORD

Vaccine Product: _____ Dose #: ☐ 1st ☐ 2nd ☐ 3rd ☐ Booster

Lot #: _____ Expiration Date: ____/____/_____

Administration Date: _____ Administration time (HH:MM): _____

Administration Site: ☐ L Arm (LA) ☐ L Deltoid (LD) ☐ L Anterior Lateral Thigh (LALT)

☐ R Arm (RA) ☐ R Deltoid (RD ☐ R Anterior Lateral Thigh (RALT)

Vaccinator Name: _____ Vaccinator Signature: _____

PLEASE CARRY THIS FORM WITH YOU THROUGHOUT THE VACCINATION CLINIC
IT WILL BE COLLECTED FROM YOU AT CHECKOUT