Pre-Vaccination Form for COVID-19 Vaccine

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 _____

Date of Birth _____

Mother's First Name _____

Street Address _____

City, State, Zip Code _____

Phone # _____

CAIR ID# _____

Gender ☐ **Male** ☐ **Female** ☐ **Non-Binary** ☐ **Other** _____

Ethnicity _____ ☐ Decline to Answer **Race** _____ ☐ Decline to Answer

Occupation _____

	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? ☐ Moderna ☐ Pfizer _____			
3. Have you had a COVID-19 infection in the last 90 days? If yes, when? _____			
4. Have you had a vaccination in the last 14 days? If yes, which vaccine product? _____			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something?For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
6. Have you received passive antibody therapy as treatment for COVID-19? If yes, when_____			
7. Do you have a bleeding disorder or are you taking a blood thinner?			
8. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
9. Are you pregnant or breastfeeding?			

FOR COUNTY USE ONLY

Vaccine Name ☐ **Moderna** ☐ **Pfizer** **Lot Number** _____ **Route IM** ☐ **Left** ☐ **Right**

Time Administered:_____:_____ AM PM **Time Released:**_____:_____ AM PM

IMPORTANT: READ THIS BEFORE SIGNING: I have read the information contained in the Emergency Use Authorization for COVID-19 Vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that the vaccine indicated above be given to me or the person named above for whom I am authorized to make this request.

Current Emergency Use Authorization fact sheet/Vaccine Information Sheet(s) for COVID-19 Vaccine - when available.

FOR CLINICAL VISITS: I consent to receive vaccination from Siskiyou County Public Health Clinic and/or our collaborating health care partner _____.

Patient Signature _____ **Date** _____

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists

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