Prevaccination Checklist for COVID-19 Vaccines

CLINIC STAFF TO FILL OUT BOX BELOW

APPOINTMENT TIME: _____

DOSE #: _____

ID VERIFIED: ☐

INSURANCE: _____

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: _____ **GENDER:**_____

DATE OF BIRTH: _____ **PHONE NUMBER**:_____

	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 did you receive?** ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product :_____			
3. 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)*			
A component of the COVID-19 Vaccine including either of the following:			
○ **Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures.**			
○ **Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.**			
• **A previous dose of COVID-19 vaccine**			
• **A vaccine on injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but is not known which component elicited the immediate reaction.**			
4. 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)*			
5. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something other than a component of COVID-19 vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drug therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

SIGNATURE: _____ **DATE:** _____

Oroville Hospital

3/5/21 CS321620-E

Adapted with appreciation from the Immunization Action Coalition (IAO) screening

RN TO FILL OUT BOX BELOW

FORM REVIEWED BY:_____ **DATE:** _____

INJECTION SITE: (CIRCLE ONE) **LEFT DELTOID** **RIGHT DELTOID**