

Screening Questionnaire for Covid-19 Vaccine

Patient Name (please print legibly): _____

Date of Birth: ____/____/____ Phone Number: (____)____-____

Allergies: _____ Male or Female

Home Address: _____

Yes NO

☐ ☐ Is the person to be vaccinated sick today? Temperature _____

☐ ☐ Have you been diagnosed with Covid-19? If so when? _____

☐ ☐ Has the person to be vaccinated ever had a problem from or reaction to any vaccine?

☐ ☐ Has the person to be vaccinated ever had an allergy PEG (common in bowel preps)? Allergic to egg products, or feathers?

☐ ☐ Does the person to be vaccinated have an immune system problem or cancer? (Example: HIV, AIDS, Leukemia, Lymphoma)

☐ ☐ Is the person to be vaccinated taking any immune suppressing medications? (Example: Prednisone, Chemotherapy, Enbrel)

☐ ☐ Is the person to be vaccinated pregnant or breastfeeding?

☐ ☐ Has the person to be vaccinated received any vaccines in the **past 14 days**?

NO YES I understand I will need to stay for **at least 15 minutes** after injection for monitoring.

NO YES Please circle **yes** or **no** that:

I authorize my health care provider and a public health agency to collect and enter my immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my medical care and treatment. In addition, information may be released to schools in order to comply with immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

Patient Signature: _____ **Date:** _____

Form Reviewed By: _____ **Date:** _____

This section to be completed by the person administering the vaccine

Vaccine: Pfizer **Lot #:** EN6202 **Expiration Date:** 06/30/2021

Injection Site (circle one): **Left Deltoid IM** **Right Deltoid IM** **Dose 1** **Dose 2**

Signature of Person Administering Vaccine: _____

Date: _____