Screening Questionnaire for COVID-19 Vaccination

______________________________ Name (please print)

____________________ Date of birth (MM/DD/YYYY)

All Vaccines	Yes	No	Don't Know
1. Are you sick today (for example: fever, nausea/vomiting, or diarrhea)?			
2. Do you have any allergies to food, medications, a vaccine, or latex? List allergies and reactions:			
3. Have you ever had a serious reaction after receiving a vaccination? 3a. If "yes", what was the reaction?			
4. Have you had a seizure, brain or other nervous system problem or have you ever had a disease called Guillain-Barré Syndrome?			
5. Do you smoke or have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?			
5a Have you ever received the pneumococcal vaccine?			
5b. If “yes”, do you remember which vaccine you received?			
5c. If “yes”, when did you receive it or how old were you when you received this vaccine?			
6. <u>For women only</u>: Are you pregnant or is there a chance you could become pregnant during the next month?			

______________________________ Signature

____________________ Date (MM/DD/YYYY)

Check here if signature is from a legal guardian or conservator. ☐

Please write legibly. All fields are required

Patient Name	Date of Birth (MM/DD/YYYY)	Age	Sex	Email Address
	/ /			

Current Address	City

Allergies:

State	Zip Code	Contact Phone Number
		( ) -

Please **choose** one of the following for race: Black/African American American Indian/Alaska Native White Asian Native Hawaiian/Other Pacific Islanders Decline to Answer

Please choose one of the following for ethnicity: Hispanic/Latino Non-Hispanic/Latino Decline to Answer

By signing below, I certify that I have been given the current CDC Vaccine Information Statement (VIS). I have read this document and have no further questions at this time. I understand the risks and benefits of receiving any vaccine. I understand that there are no guarantees concerning the effectiveness of the vaccine. I understand the possible side effects and warnings of the vaccine. I acknowledge that the vaccine is being administered as part of an educational activity for health profession students enrolled at the University of the Pacific. I certify that I received the vaccines noted below and request that payment of authorized benefits be made on my behalf. Additionally, by signing, I attest that I have reviewed the University of the Pacific "Notice of Privacy Practices" Statement.

Signature: ______________________________ Date: ____________ MM/DD/YYYY

☐ Check here if signature is from a legal guardian or conservator.

Do not write below this line

Vaccine Name	NDC	Lot #	Mfg. Name	Exp. Date	Route	Site	Dosage	VIS/EUA Date	Date VIS/EUA Given	Initials	Registry
					IM	Deltoid L / R					
					IM	Deltoid L / R					

Immunizer signature	Print name	Date (MM/DD/YYYY)

Professional category: ☐ Dentist ☐ MD or DO ☐ RN or NP ☐ PA ☐ PharmD Other____________