Prevaccination Checklist for COVID-19 Vaccination

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 _____

Age _____

	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(s) did you receive?			
☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	☐	☐	
3. Check all that apply:	☐	☐	☐
☐ I live in a long-term care setting.			
☐ I have been diagnosed with a medical condition(s). Please list: _____			
☐ I am a first responder.			
☐ I work in a long-term care facility, correctional facility, hospital, restaurant, retail setting, school, or other setting with high exposure to the public.			
4. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematocrit therapy [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)*	☐	☐	☐
5. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	☐	☐	☐
6. 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 caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a 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	☐	☐	☐

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	Yes	No	Don't know
7. 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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

8. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ Have a history of Guillain-Barré Syndrome (GBS)

Vaccine Administered	Lot Number	Exp. Date (mm/dd/yyyy)
☐ Moderna (COVID-19)		
☐ Janseen (COVID-19)		

Dose Administered (1st, 2nd, 3rd, Booster)	Vaccinator

Side of Administration (Intramuscular)	Recipient received EUA?
☐ Left	☐ Yes
☐ Right	☐ No

Form reviewed by _____ **Date** _____

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

East Shore District Health Department
COVID-19 Vaccination Form

Information will be entered into CT WIZ
Connecticut Immunization System

First Name: _____ Clinic Location: _____

Middle Name: _____ Email: _____

Last Name: _____ Phone number: _____

Sex: Male Female Transgender Unknown Date of Birth: ____/____/____ mm dd yyyy

***Dose you are here for? (Choose 1):** 1st, 2nd, 3rd, Booster ***Brand (Choose 1):** Moderna or J&J

Insurance Information:

Insurance Company: _____ ID # : _____

Subscriber: _____ DOB: _____

Address:

Street: _____ County: _____

Street 2: _____ State: _____

City: _____ Zip Code: _____

Race (select all that apply)

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other Race
- ☐ Unknown

Ethnicity (select all that apply)

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Patient Authorization for Vaccine Administration:

I have read or had explained to me the 2020-2021 Vaccine Information Statement for the COVID-19 vaccine and understand the risks and benefits. Furthermore, I have also had an opportunity to ask about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunization(s) by the person named below for whom I am the legal guardian ("Ward"). My medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to me or my Ward. I, for myself and on behalf of my Ward and each of our respective heirs, executors, personal representatives and assigns, hereby release the provisioning mass vaccination center, and it's affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt of my Ward of this or these immunization(s). Neither the provisioning mass vaccination center nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. The provisioning vaccine center will use and disclose your personal and health information or the personal and health information of your Ward, to treat you or your Ward, to receive payment of the care we provide, and for other healthcare operations. Healthcare operations include those activities we perform to improve the quality of care.

Signature: _____ Date: _____