**Appointment Time: Exit Time:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Demographic Information** | | | |  |
| First Name |  | Middle Name | Last Name |  |
| Date of Birth |  | Age | SSN |  |
| Gender |  | Prim. Language | Translation By |  |
| Marital Status |  | Race | Ethnicity |  |
| Phone |  | E-Mail |  |  |
| Street Address |  |  |  |  |
| City |  | State |  |  |
| Zip |  | County |  |  |
| Employer |  | Occupation |  |  |

These questions will help 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. If a question is not clear, please ask the provider to explain.

|  |  |  |  |
| --- | --- | --- | --- |
| **Screening Questions** | **Yes** | **No** | **Unsure** |
| 1. Are you feeling sick today? |  |  |  |
| 2. Do you currently have an active infectious respiratory illness or fever? |  |  |  |
| 3. Have you ever had a severe allergic reaction to any vaccines? |  |  |  |
| 4. Have you received any other vaccines within the past 14 days? If yes, which one(s) |  |  |  |
| 5. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product?  Pfizer \_ Moderna Another Product \_ |  |  |  |
| 6. Have you ever had an allergic reaction to: | | | |
| A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in  * some medications, such as laxatives and preparations for colonoscopy procedures |  |  |  |
| * Polysorbate |  |  |  |
| * A previous dose of COVID-19 vaccine |  |  |  |
| 7. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies |  |  |  |
| 8. Have you received another vaccine in the last 14 days? |  |  |  |
| 9. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? |  |  |  |
| 10. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? |  |  |  |
| 11. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? |  |  |  |
| 12. Do you have a bleeding disorder or are you taking a blood thinner? |  |  |  |
| 13. Are you pregnant or breastfeeding? |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **FOR VACCINATOR USE ONLY** | | | | |  |
| Manufacturer |  |  | Lot Number | Expiration Date |  |
| Route of Admin. |  | Site | *R Deltoid / L Deltoid / R Thigh / L Thigh* | Date Admin. |  |
| Signature of Administrator |  |  |  | VIS |  |

I consent that the vaccinator administers the Covid-19 vaccine to the above-named person. I have had adequate opportunity to ask pertinent questions regarding the safety, value and possible side effects of the vaccine. I have received relevant Vaccine Information Statements. I will hold the vaccinating entity and its representatives free from any liabilities that may arise as a result of the vaccine received.