Lynn Community health CENTER

PRE-VACCINATION CHECKLIST

FOR COVID-19 VACCINES & VACCINE CONSENT

Patient Label
MRN:

Section 1: Patient information (please print)

LAST NAME:	FIRST NAME:	Date of Birth: / /	Age:

Section 2: Information to determine if you should receive the COVID19 vaccine

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 health care provider to explain it.	NO	YES	DO NOT KNOW	For LCHC use only (initial for any yes responses that you reviewed with patient) Form reviewed by: _____
1. Have you ever received a dose of COVID-19 Vaccine? ▪ If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen/J&J ☐ Another product:				Dose #
2. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?				Allergist (Y/N)
3. Have you ever had an allergic reaction to previous dose of COVID-19 vaccine?				No vaccine
4. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something other than a component of COVID19 vaccine, polysorbate, or any vaccine or injectable medication? (E.g. food, pet, environment, oral medication allergies)				Observation Time:
5. Have you received any vaccine in the last 14 days?				Rebook online 14 days
6. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 in the past 90 days?				Last 90 days? Rebook

Section 3: Consent

CONSENT FOR VACCINATION: I have read or had explained to me the Emergency Use Authorization (EUA) fact sheet for the COVID-19 vaccine and understand the risks and benefits. In receiving this vaccination, I understand that I may experience symptoms of headache, body aches, general malaise and possible fever. This does not indicate a COVID-19 infection but rather my body's immune response to the vaccine. In accordance with 105 CMR 220.100, all immunizations will be reported to the Massachusetts Immunization Information System (MIIS)

By signing this form, **I GIVE MY FULL CONSENT** to receive the COVID-19 vaccine on my own will and understand that I might need to get two doses of the vaccine depending on the vaccine formulation. I also understand that this vaccine is being administered under the Emergency Use Authorization (EAU) and has not yet received full FDA approval. I will notify my primary care provider or go to ER should I experience a severe reaction.

Signature of Individual Receiving a Vaccine:	Date signed:

Section 4: Vaccine administration documentation

Vaccinator Name:	Administration date:	Site: Right deltoid Left deltoid

Emergency Documentation Purposes only

Source: ☐ State ☐ Federal		
Manufacturer ☐ Moderna ☐ Pfizer ☐ Janssen	Lot #	Expiration Date