Prevaccination Checklist for COVID-19 Vaccines

Patient Label
MRN:

For LCHC only

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.

Patient Name _____

Age _____ **Date of Birth** ____/____/____

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.	**Yes**	**No**	**Don't know**	For LCHC use only (initial for any yes responses that you reviewed with pt)
1. ~~Are you feeling sick today?~~ Not applicable – Temperature taken upon entrance				
2. Have you ever received a dose of COVID-19 vaccine? • If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Another product _____				Dose #
3. 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) • 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				No Vaccine
• Polysorbate				
• A previous dose of COVID-19 vaccine				
4. 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)				Allergist (Y/N)?
5. 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.				Observation Time:
6. Have you received any vaccine in the last 14 days?				Rebook online 14 days
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?				
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?				Last 90 days? Rebook
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?				
10. Do you have a bleeding disorder or are you taking a blood thinner?				
11. Are you pregnant or breastfeeding?				

Form reviewed by _____ **Date** _____

Vaccinator Name _____ **Vaccination side:** **L** **R**