PARTNERS 4KIDS

Pre-Vaccination Checklist for COVID-19 Vaccines

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.

	Yes	No	Don't Know
1. Are you feeling sick today? *Review signs of COVID-19*			
2. Have you ever received a dose of COVID-19 vaccine? • If yes, which vaccine product? -Pfizer -Moderna -Another Product			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something.? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital? • Was the severe allergic reaction after receiving a COVID-19 vaccine? • Was the severe allergic reaction after receiving another vaccine or another injectable medication			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

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

CONSENT: I have been informed about and offered the opportunity to receive the COVID-19 vaccine at no cost to me. I understand that a second dose may be required to develop immunity. However, as with any medical treatment, there is no guarantee that I will become immune to all strains of COVID-19 or that I will not experience adverse side effects from the vaccine. I accept the offer at this time.

I have NOT previously received the COVID-19 Vaccination

Patient Name: (print) _____ DOB:_____

Signature _____ Date: _____

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