Screening Questionnaire for COVID-19 Vaccines

(Please fill out form for each person receiving a vaccination today)

Each patient must complete this form to be vaccinated. The following questions will help us determine if there is any reason we should not give you a COVID-19 vaccination today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask clinic staff to explain it.

Please answer the following questions. Mark YES or NO:

1. Are you feeling sick today?	☐Yes ☐ No
2. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Another product _____	☐Yes ☐ No
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.)	☐Yes ☐ No
• 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	☐Yes ☐ No
• Polysorbate	☐Yes ☐ No
• A previous dose of COVID-19 vaccine	☐Yes ☐ No
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.)	☐Yes ☐ No
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.	☐Yes ☐ No
6. Have you received any vaccine in the last 14 days?	☐Yes ☐ No
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐Yes ☐ No
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐Yes ☐ No
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?	☐Yes ☐ No
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐Yes ☐ No
11. Are you pregnant or breastfeeding?	☐Yes ☐ No

FOR CLINIC STAFF ONLY

Vaccine Type: ☐ Moderna Injectable ☐ Pfizer Injectable	Injection Site: ☐ Left ☐ Right	Place all Lot # Stickers HERE
Vaccinator Last Name:		
Clinic Type: ☐ Community ☐ MPOD ☐ Closed MPOD	Clinic Date:	

Station Throughput Timing:

Greeting _____ Screening _____ Dispensing _____ Exit _____

Personal Information for COVID-19 Vaccines

(Please fill out form for each person receiving a vaccination today)

Each patient must have a completed form to be vaccinated. The information on this form should be filled in for the person receiving the vaccination today. A separate form should be used for each member of your family ***IF*** multiple people are receiving vaccine today.

PLEASE PRINT CLEARLY!

First Name:	Last Name:	
Middle Name:	Sex (Gender): ☐ Male ☐ Female ☐ Prefer not to answer	
Date of Birth (MM/DD/YYYY):	Age:	
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Other ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African-American		
Ethnicity: ☐ Hispanic or Latino ☐ Other		
Phone:	E-mail:	
Address:	City:	Zipcode:
Occupation:		

How did you hear about the clinic today?

☐ Website ☐ Newspaper ☐ Flyer ☐ Social Media ☐ Other:_____

My signature below indicates that (please sign at the clinic):

- I have read or had explained to me the "Emergency Use Authorization of the Moderna or Pfizer BioNTech COVID-19 Vaccine" (EUA).
- I had an opportunity to ask questions which were answered to my satisfaction.
- I believe I understand the benefits and risks of COVID-19 vaccine and request that it be given to me or to the person for whom I am authorized to make the request.
- I have been provided with a copy of the Notice of Privacy Practices.
- I have answered the questions on the next page to the best of my ability.
- I understand that my vaccination record will be kept in the California Immunization Registry (CAIR) database.

X

Signature/Guardian **Today's Date** **Relationship of Guardian**

FOR CLINIC STAFF USE ONLY

Patient ID Number Sticker:	Priority Phase and Tier: