Screening Questionnaire for Vaccination

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

Each patient must complete this 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!**

The following questions will help us determine if there is any reason, we should not give you or your child **Influenza** (**Flu) / COVID-19** vaccines today. If you answer "yes" to any question, it does not necessarily mean you (or your child) 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:

Is the person to be vaccinated sick today?	☐ Yes ☐ No
Have you received a monkeypox vaccine within the last 4 weeks?	☐ Yes ☐ No
Have you ever received a dose of COVID-19 vaccine?	☐ Yes ☐ No
Which vaccine product did you receive?	☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen (Johnson & Johnson)
Did you bring your vaccination record card or other documentation?	☐ Yes ☐ No
CAIR ID:	☐ Vaccinated out of state ☐ Vaccinated outside the US

Have you ever had an allergic reaction to:

A component of a COVID-19 vaccine, including either of the following:	
Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐ Yes ☐ No
Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	
A previous dose of COVID-19 vaccine	☐ Yes ☐ No
Another vaccine (other than COVID-19 vaccine) or an injectable medication	☐ Yes ☐ No

Allergic reactions include 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 caused hives, swelling, or respiratory distress, including wheezing.*

Check all that apply to you:	☐ None of these apply	☐ Had COVID-19
☐ History of myocarditis or pericarditis	☐ Have a bleeding disorder	☐ Take a blood thinner
☐ Have a history of heparin-induced thrombocytopenia (HIT)	☐ Have a history of Guillain-Barré Syndrome (GBS)	☐ Are currently pregnant or breastfeeding
☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies	☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum	☐ Have received dermal fillers
☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food **(eggs),** pets, venom, environment or medication	☐ Was diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection	Child's weight / Temperature

First name:	Last name:	
Sex (Gender): ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to answer		
Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ African-American/Black ☐ Pacific Islander/Native Hawaiian ☐ Caucasian/White ☐ Other race:		Hispanic or Latino? ☐ Yes ☐ No
Date of birth (MM/DD/YYYY):	Address:	
Age:	City:	Zip code:
Phone:	Email:	
If you couldn't get vaccinated here today with us, where would you get vaccinated?		

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

- I have read or had explained to me the "EUA Vaccine Fact Sheet for Recipients and Caregivers." **And/or** "Influenza (Flu)Vaccine Immunization Statement (VIS)"
- I had an opportunity to ask questions which were answered to my satisfaction.
- I believe I understand the benefits and risks of **Flu / COVID-19** vaccines 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 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 ONLY

Vaccine types (Check all):	Injection site (F for Flu, C for COVID):	Place Lot # Stickers here	Data entry stamp
☐ Pfizer ☐ Moderna ☐ J&J ☐ Fluarix ☐ Afluria	☐ Left arm ☐ Right arm ☐ Left leg ☐ Right leg		
Vaccinator name:			Vaccination date: