

**Prevaccination Checklist** **for COVID-19 Vaccination**

 Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **For vaccine recipients (both children and adults):**

The following questions will help us determine if there is any reason COVID-19 vaccine cannot be given today. If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given. It just means additional questions may be asked. If a question is not clear, please ask the healthcare provider to explain it.

1. How old is the person to be vaccinated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Is the person to be vaccinated sick today? \_\_\_\_\_YES \_\_\_\_NO
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine? \_\_\_\_\_YES \_\_\_\_NO
* If yes, which vaccine product was administered?

 \_\_\_\_\_\_\_Pfizer-BioNTech \_\_\_\_\_\_\_\_Moderna

 \_\_\_\_\_\_\_Janssen *(Johnson & Johnson)*  \_\_\_\_\_\_\_\_Novavax \_\_\_\_\_\_\_\_Another Product

* How many doses of COVID-19 vaccine were administered? \_\_\_\_\_\_\_\_\_\_\_\_\_
* Did you bring the vaccination record card or other documentation? \_\_\_\_\_YES \_\_\_\_\_NO

 4. Is the person to be vaccinated have a health condition or undergoing treatment that \_\_\_\_\_YES \_\_\_\_\_NO

 makes them moderately or severely immunocompromised? *This would include, but not*

 *limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy, or high dose*

 *corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary*

 *immunodeficiency*

 5. Is the person to be vaccinated received COVID-19 vaccine before or during \_\_\_\_\_YES \_\_\_\_\_NO

 hematopoietic cell transplant (HCT) or CAR-T-cell therapies?

6. Has the person to be vaccinated ever had an allergic reaction to: \_\_\_\_\_YES \_\_\_\_\_NO

 (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 causes hives, swelling, or respiratory distress, including wheezing.)

* A component of a COVID-19 vaccine \_\_\_\_\_ YES \_\_\_\_\_NO

* A previous dose of COVID-19 vaccine \_\_\_\_\_YES \_\_\_\_\_NO

 7. Has the person to be vaccinated ever had an allergic reaction to another vaccine \_\_\_\_\_YES \_\_\_\_\_NO

 (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 caused hives,*

 *swelling, or respiratory distress, including wheezing.)*

 8. Check all that apply to the person to be vaccinated:

 \_\_\_\_\_\_Have a history of myocarditis or pericarditis \_\_\_\_\_\_Have a history of Guillain-Barré Syndrome (GBS)

 \_\_\_\_\_\_Have a history of Multisystem Inflammatory Syndrome \_\_\_\_\_\_Have a history of COVID-19 disease within the past 3

 (MIS-C or MIS-A)? months

 \_\_\_\_\_\_History of an immune-mediated syndrome defined by \_\_\_\_\_\_Have a history of thrombocytopenia syndrome (TTS)

 Thrombosis and thrombocytopenia, such as heparin-induced

 thrombocytopenia (HIT)

I received and read the Emergency Use Authorization or other applicable fact sheet information regarding the possible side effects,

risks and contraindications of the COVID-19 vaccine. Bowdle Healthcare will disclose this immunization to the appropriate State Immunization Registry Database

If the named individual is under the age of 18, as parent or guardian, I acknowledge receipt of the Emergency Use of Authorization or applicable and consent to have Pfizer or Moderna vaccine administered to him/her.

Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ADMINISTRATIVE USE ONLY:

|  |  |
| --- | --- |
| **Vaccine: Covid 19** |  **Please Circle One****Pfizer-BioNTech Moderna**  |
| **Date & Time Vaccine****Administered** | **Vaccine Manufacturer/Lot Number/Expiration Date** | **Site** | **Signature & Title of Vaccine Administrator** |
|  |  |  |  |