

**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. Is the person to be vaccinated sick today? \_\_\_\_\_YES \_\_\_\_NO
2. Has the person to be vaccinated ever received a dose of COVID-19 vaccine? \_\_\_\_\_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 a prior dose \_\_\_\_\_YES \_\_\_\_\_NO

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

 or an injectable medication?

 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

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

 ADMINISTRATIVE USE ONLY:

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