COVID-19 Vaccine Pre-Screening Form

Please complete the following questionnaire prior to receiving your vaccine.

If a question is not clear, please ask your healthcare provider to explain it.

	YES	NO
1. Are you feeling sick or do you have a fever today?	_____	_____
2. Are you moderately or severely immunocompromised?	_____	_____

3. Date of last vaccination/booster? _____

4. Which vaccine product would you like to receive today?

- ❑ **MODERNA/ SPIKEVAX** . . . . . .Primary: 12 yrs + (100mcg/0.5 mL)
- ❑ **MODERNA BIVALENT** . . . . . .Booster 18+ years (50mcg/0.5 mL)
- ❑ **PFIZER/COMIRNATY** . . . . . .Pediatric: 6 months – 4 years (3mcg/0.2 mL)
- ❑ **PFIZER/COMIRNATY** . . . . . .Pediatric: 5-11 years (10mcg/0.2 mL)
- ❑ **PFIZER BIVALENT** . . . . . .Pediatric Booster 5-11 years (10mcg/0.2 mL)
- ❑ **PFIZER/COMIRNATY** . . . . . .Primary 12+ years (30 mcg/0.3 mL)
- ❑ **PFIZER BIVALENT** . . . . . .Booster 12+ years (30 mcg/0.3 mL)

5. 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.)

• A component of the 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	_____	_____
- Polysorbate, which is found in some vaccines, film coated tablets and intravenous steroids	_____	_____
• A previous dose of COVID-19 vaccine	_____	_____
• Another vaccine (other than COVID-19 vaccine) or an injectable medication?	_____	_____
• Food, pet, venom, environmental or oral medication allergies?	_____	_____

6. Check all that apply to you:

- ❑ Am a female between ages 18 and 49 years old
- ❑ Had tested positive for COVID-19 in the past 10 days
- ❑ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ❑ Do you have a bleeding disorder or are you taking a blood thinner?
- ❑ Have a history of heparin-induced thrombocytopenia (HIT)
- ❑ Are you pregnant or breastfeeding (nursing)?
- ❑ Have received dermal fillers

We will review this form with you prior to your vaccination to answer all of your questions about any "yes" answer above. Patients who have had some types of allergic reactions in the past may require a 30 minute observation after the vaccine. I have received the Fact Sheet for the COVID-19 Vaccine that I am receiving.

Print Name_____ Signature_____

Date_____ Date of Birth_____ Age _____ Phone _____

Address _____City_____State_____Zip_____

Parent/Legal Guardian Signature
if applicable or under age 18 years: _____ Print name_____