PRE-VACCINATION CHECKLIST FOR COVID-19 VACCINE

Patient Name: _____ Date: _____ Facility / Community Name: _____

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

		Yes	No	Don't Know
1.	Are you feeling sick today?			
2.	Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
3.	Have you ever received a COVID-19 Vaccine? If yes, which brand did you receive? □ Pfizer □ Moderna □ J&J □ Other Date of last dose: _____ and Which dose did you receive: _____			
4.	Have you ever had an allergic or severe allergic reaction (anaphylaxis) that required treatment with epinephrine or Epi-Pen that caused you to go to the hospital? This would also include an allergic reaction that occurred within 4 hours that caused hives, swelling or respiratory distress, including wheezing:			
	a. A component of the COVID-19 vaccine?			
	b. Polysorbate or polyethylene glycol?			
	c. A previous dose of COVID-19 vaccine?			
5.	Have you ever had an allergic reaction to another vaccine (other than COVID-19) or an injectable medication?			
6.	Have you ever had a severe allergic reaction (anaphylaxis) to something other than a component of COVID-19 vaccine? This would include food, pet, environmental or oral medications?			
7.	Have you received any vaccine in the last 14 days?			
8.	Have you received monoclonal antibodies or convalescent serum as treatment for COVID-19 (90 day waiting period)?			
9.	Do you have a weakened immune system caused by something such as HIV infection, cancer or do you take immunosuppressive drugs or therapies?			
10.	Do you have a bleeding disorder or are you taking a blood thinner (Warfarin)?			
11.	Are you pregnant or breast feeding?			

Form Reviewed by: _____ Date: _____

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COVID-19 VACCINE CONSENT AND ADMINISTRATION RECORD

FACILITY/COMMUNITY NAME: _____ PHONE: _____

COVID-19 vaccine dose needed: □ First, □ Second, □ Immuno-compromised, □ Booster, □ 2nd Booster or □ 3rd Booster
COVID-19 vaccine requested: □ Moderna, □ Pfizer

RESIDENT REGISTRATION (Must complete all sections):

Full Name: _____ Date of Birth: ____ / ____ / ____

□ Male or □ Female Race: _____ Ethnicity: □ Hispanic/Latino or □ Neither

Medicare # _____ (Required for Medicare Part-B billing of the vaccine for all residents age 65 and older; or Medicare eligible. Refer to the Red, White and Blue Card)

EMPLOYEE REGISTRATION (Must complete all sections):

Full Name: _____ Date of Birth: ____ / ____ / ____ Cell: _____

□ Male or □ Female Race: _____ Ethnicity: □ Hispanic/Latino or □ Neither

Address: _____ City: _____ State: ___ Zip: _____

Do you have prescription (Rx) insurance? □ Yes □ No (if yes, include a copy of the Rx insurance card).
Prescription Benefit Plan Name: _____ Cardholder # _____
Rx Grp _____ Rx BIN # _____ Rx PCN # _____

CONSENT FOR SERVICES:

I have been provided with the Vaccine Information Sheet or patient fact sheet corresponding to the vaccine that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should call 911. I request that the vaccine be given to me or to the person above for whom I am authorized to make this request. I also consent to receive annual/repeat vaccines per CDC guidelines from this date forward.

X: _____ Date: _____
(Signature of recipient to receive vaccine or guardian or authorized representative)

Vaccine Name	Vaccine Maker	Vaccine Lot #	Date Administered	Volume Administered (mL)	Dose Administered	Injection Site: L or R	Signature of Vaccine Administrator	Title
COVID-19								
COVID-19								

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