# Prevaccination Checklist for COVID-19 Vaccination

**Name** _____

## For vaccine recipients (both children and adults):

Age _____ DOB _____

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.

| | Yes | No | Don't know |
|---|---|---|---|
| **1.** How old is the person to be vaccinated? _____ | | | |
| **2.** Is the person to be vaccinated sick today? | ☐ | ☐ | ☐ |
| **3.** Has the person to be vaccinated ever received a dose of COVID-19 vaccine? | ☐ | ☐ | ☐ |
| • If yes, which vaccine product was administered? ☐ Pfizer-BioNTech ☐ Janssen *(Johnson & Johnson)* ☐ Another Product ☐ Moderna ☐ Novavax _____ | | | |
| • How many doses of COVID-19 vaccine were administered? _____ | | | |
| • Did you bring the vaccination record card or other documentation? | ☐ | ☐ | |
| **4.** Does the person to be vaccinated have a health condition or is undergoing treatment that makes them moderately or severely immunocompromised? *This would include, but not be 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.** Has the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies? | ☐ | ☐ | ☐ |
| **6.** Has the person to be vaccinated 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 caused hives, swelling, or respiratory distress, including wheezing.)* | | | |
| • A component of a COVID-19 vaccine | ☐ | ☐ | ☐ |
| • A previous dose of COVID-19 vaccine | ☐ | ☐ | ☐ |
| **7.** Has the person to be vaccinated ever had an allergic reaction to another vaccine (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 Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months?
- ☐ Vaccinated with monkeypox vaccine in the last 4 weeks?

**Form reviewed by** _____ **Date** _____



Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists

## Recipient Medical Questionnaire and Consent

*I have read or had explained to me the 2024-2025 Vaccine Information Statement for the COVID-19 vaccine and understand the risks and benefits. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunization(s) by the person named below for whom I am the legal guardian ("Ward"). My medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to me or my Ward. I, for myself and on behalf of my Ward and each of our respective heirs, executors, personal representatives and assigns, hereby release the provisioning mass vaccination center, and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released parties"), from any and all claims arising out of, in connections with or in any way related to my receipt and the receipt of my Ward of this or these immunization(s). Neither the provisioning mass vaccination center nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. The provisioning vaccination center will use and disclose your personal and health information or the personal and health information of your Ward, to treat you or your Ward, to receive payment of the care we provide, and for other healthcare operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to you and your Ward's personal health information.*
*https://www.cdc.gov/other/privacy.html*

☐ **I acknowledge that I have received a copy of the Notice of Privacy Practices.**

☐ **I acknowledge that I have received notice about reporting to CT Wiz.**

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**Signature**

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**Print: Last Name, First Name**

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**Address**

**Insurance (circle one): Anthem/Blue Cross Connecticare Medicare Cigna Aetna**
**Other-Please Specify:**
**Member ID#:** _____

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***TO BE COMPLETED BY CLINIC STAFF ONLY:***

**PRODUCT NAME & LOT#:** _____

**VIAL NUMBER:** _____ **VACCINATOR NAME:** _____

**Injection Site: Left Arm Right Arm**