Prevaccination Checklist for COVID-19 Vaccination

Name _____

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **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. How old are you? _____			
2. Are you feeling sick today?	☐	☐	☐
3. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product(s) did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	☐	☐	
4. Do you have a health condition or are you undergoing treatment that makes you 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. Have you received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. 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 caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. Have you 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 you:

- ☐ 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?

Form reviewed by _____ **Date** _____

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

HEALTHY GALLATIN

COVID-19
VACCINE ADMINISTRATION RECORD

Last Name:	First Name:	Middle:	DOB:	Age:	Sex:

Phone(Include area code)	Race:	Ethnicity:

Email:

Address:	City	State:	Zip

☐ I consent to the shared use of demographic information and authorize my Covid19 vaccine to be recorded into the State of Montana Immunization Registry for immunization health purposes and that it may be released to health care providers, childcare providers and schools across the state that may provide continuing immunization services.
I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department.

By signing this form, I am requesting vaccination services for myself and/or the persons identified, of whom I am authorized to sign. A copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Statement(s) has been provided. I have read the information about the disease(s) and the vaccine(s) listed. I believe that I understand the benefits and risks of the vaccine(s) cited and ask that the vaccine(s) listed be given to me or to the person named (for whom I am authorized to make this request).

Patient Signature:_____Date:_____

VACCINE ADMINISTRATOR: YOU MUST FILL OUT ALL FIELDS BELOW AND SIGN

Date Vaccinated:	Signature & title of Vaccine Administrator:	EUA Given: check below

Vaccine

_____ **Lot Number**

_____ **Manufacturer**

_____ **Injection Site**

_____ **Expiration Date**

Dose: 1 2 3 4 please circle