Prevaccination Checklist for COVID-19 Vaccines

Please bring your ID and pharmacy insurance card to your appointment.

Eastside Family Pharmacy

Patient Name _____ **Date of Birth** _____

Address _____

Phone _____

Email _____

Check one:
- ☐ Hispanic Origin
- ☐ Non-Hispanic Origin
- ☐ Unknown
- ☐ I prefer to not answer

Check one:
- ☐ Native American or Alaskan
- ☐ African American or Black
- ☐ Native Hawaiian or Pacific Islander
- ☐ Asian
- ☐ White
- ☐ Multiracial/Other
- ☐ I prefer not to answer

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product _____			
3. 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 a 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.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers? (Examples include Juvederm, Restylane, Belotero, Sculptra and Radiesse.)			

Last Updated: April 6, 2021

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Consent

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

Recipient Signature **Date / Time** **Print Name**

Area Below to be Completed by Vaccinator

Which vaccine is the patient receiving today?

Vaccine Name	Administration		Dosage	Lot Number
Pfizer/ BioNTech	□ First Dose	□ Second Dose	0.3 mL	
Moderna	□ First Dose	□ Second Dose	0.5 mL	
Astra-Zeneca	□ First Dose	□ Second Dose	0.5 mL	
Janssen	□ Single Dose		0.5 mL	

Administration Site: ☐ Left Deltoid ☐ Right Deltoid

□ I have reviewed side effects with patient (and parent, guardian or surrogate, as applicable)

□ I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them have been answered correctly and to the best of my ability.

Vaccinator Signature: _____