



# Screening Questionnaire for COVID-19 Vaccines

(Please fill out form for each person receiving a vaccination today)

**Each patient must complete this form to be vaccinated.** The following questions will help us determine if there is any reason we should not give you a COVID-19 vaccination today. If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask clinic staff to explain it.

## Please answer the following questions. Mark YES or NO:

1. Are you feeling sick today?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Another product _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Polysorbate	<input type="checkbox"/> Yes <input type="checkbox"/> No
• A previous dose of COVID-19 vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No
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.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you received any vaccine in the last 14 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Do you have dermal fillers?	<input type="checkbox"/> Yes <input type="checkbox"/> No

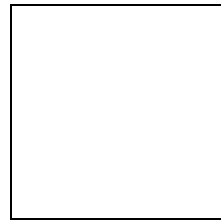
### FOR CLINIC STAFF ONLY

Vaccine Type: <input type="checkbox"/> Moderna Injectable <input type="checkbox"/> Pfizer Injectable <input type="checkbox"/> Janssen Injectable	Injection Site: <input type="checkbox"/> Left <input type="checkbox"/> Right	Place all Lot # Stickers HERE					
Vaccinator Last Name:							
Clinic Type: <input type="checkbox"/> Community <input type="checkbox"/> MPOD <input type="checkbox"/> Closed MPOD	Clinic Date:						
Station Throughput Timing:							
Greeting	<input type="text"/>	Screening	<input type="text"/>	Dispensing	<input type="text"/>	Exit	<input type="text"/>



# Personal Information for COVID-19 Vaccines

(Please fill out form for each person receiving a vaccination today)



**Each patient must have a completed form to be vaccinated.** The information on this form should be filled in for the person receiving the vaccination today. A separate form should be used for each member of your family *IF* multiple people are receiving vaccine today.

**PLEASE PRINT CLEARLY!**

First Name:	Last Name:	
Middle Name:	Sex (Gender): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer	
Date of Birth (MM/DD/YYYY):	Age: _____ (Please circle age if under 18 yrs old)	
Do you consider yourself Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American		
Phone:	E-mail:	
Address:	City:	Zip code:
Occupation:		

How did you hear about the clinic today? <input type="checkbox"/> Website <input type="checkbox"/> Newspaper <input type="checkbox"/> Flyer <input type="checkbox"/> Social Media <input type="checkbox"/> Other: _____
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My signature below indicates that (please sign at the clinic):

- I have read or had explained to me the “Emergency Use Authorization of the Moderna, Pfizer BioNTech, or Janssen COVID-19 Vaccine” (EUA).
- I had an opportunity to ask questions which were answered to my satisfaction.
- I believe I understand the benefits and risks of COVID-19 vaccine and request that it be given to me or to the person for whom I am authorized to make the request.
- I have been provided with a copy of the Notice of Privacy Practices.
- I have answered the questions on the next page to the best of my ability.
- I understand that my vaccination record will be kept in the California Immunization Registry (CAIR) database.

**X**

Signature/Guardian	Today's Date	Relationship of Guardian
<b>FOR CLINIC STAFF USE ONLY</b>		

Patient ID Number Sticker:	Priority Phase and Tier:
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