Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name ______________________

Age __________

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. 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?			

Form reviewed by ______________________ **Date** ______________

Clic: ______________________________________ Today's Date: ___________________

COVID-19 Vaccination Form

Please complete each field below with the information that applies to the client receiving services today.

CLIENT INFORMATION				
Name (Last, First, MI) , ,		Suffix (eg., Jr, III)	Date of Birth	Age†
Street Address	City	State	Zip	County
Phone Number ( ) ☐ Cell ☐ Home	Sex ☐ Female ☐ Male ☐ Other ☐ Unknown	Race ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other	Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown	

If the client is under 18 years of age, please complete guardian information.
Guardian relationship to client: ☐ Father ☐ Mother ☐ Legal Guardian ☐ Other **Guardian Name (Last, First)** ____________________, ________________________, ___

CONSENT FOR SERVICE

I, the undersigned, give my consent for the services that I am requesting from the Oklahoma State Department of Health (OSDH) and its entities/contractors. I understand that:

-- the risks and benefits for these services will be explained to me and that I will have the opportunity to ask questions.

-- the information regarding myself and the services I receive will be entered into OSDH management information systems and may be used for program evaluation, management, and billing purposes.

-- I may refuse service at any time.

I acknowledge that I have received a copy of the Oklahoma State Department of Health Privacy Statement as required by the Health Information Portability and Accountability Act (HIPAA). I can also find a copy on the agency website. I also acknowledge that I received the manufacturer-specific Fact Sheet for Recipients and Caregivers prior to receiving the vaccine.

Client/Guardian Signature: ____ Date: ____________________

†Client must be aged 16 years or older to receive the Pfizer vaccine and aged 18 years or older to receive the Moderna vaccine

****FOR OSDH USE ONLY****

Client Name (Last, First, MI) ________________________,_________________________,___ Client DOB (MM/DD/YYYY)____________________________________

OFFICE USE ONLY – DO NOT WRITE BELOW			
Client completed the manufacturer's screening questions: ☐ Y ☐ N			
Vaccine Manufacturer: Lot #: Exp. Date:	Site: ☐ LT DELTOID IM ☐ RT DELTOID IM ☐ LT VAST LAT IM ☐ RT VAST LAT IM	EUA*/VIS given? ☐ Y ☐ N Reaction? ☐ Y ☐ N	Dose Number: ☐ 1st ☐ 2nd
Vaccination Complete? ☐Complete ☐Refused ☐Not administered ☐Partially administered ☐No recorded completion status			
Provider Signature:			

*EAU = Emergency Use Agreement

Progress Note:____

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