Pre-Vaccination Checklist for COVID-19 Vaccines

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.

Patient Name _____

Age _____

Date of Birth _____

	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? ☐ Pfizer ☐ Moderna ☐ Another product _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

Please continue to the back page.

Form reviewed by _____ **Date** _____

	Yes	No	Don't Know
10. Have you had a COVID-19 infection in the last 30 days?			
11. Have you had close contact with a COVID-19 positive person in the last 14 days?			

I have read, or given the information about the disease and vaccine listed below:

FACT SHEET FOR RECIPIENTS AND CAREGIVERS
EMERGENCY USE AUTHORIZATION (EUA) OF
THE MODERNA COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019
(COVID-19) IN INDIVIDUALS 18 YEARS OF AGE AND OLDER

I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine cited and ask the vaccine below be given to me or to the person named above (for whom I am authorized to make this request.) I understand that it is recommended I stay on location for 15 minutes following the injection.

X_____ Date_____
Signature of person to receive vaccine (or person authorized to make the request)

For Clinic Use Only

COVID-19 VACCINE	Manufacturer: MODERNA	GTIN 00380777273990 Lot 027L20A Exp. 12/31/2069	Date Given	Site L / R Deltoid	Initials	EHR	