Pre-vaccination Checklist for COVID-19 Vaccines

To be completed on day of vaccination

Patient Name: _____ **Patient DOB:** _____

Today's date: _____

	Yes	No	Unsure
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. Itwould 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 andpreparations 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-19vaccine 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 aninjectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or thatcaused 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 componentof 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) astreatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or doyou 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?			

For office use only

IM Route Site	Dose	Manufacturer (MVX)	Lot # Unit of Use/ Unit of Sale	Expiration Date	Date of EUA Fact Sheet
☐ Left ☐ Right		☐ Janssen ☐ Moderna ☐ Pfizer			

Vaccine Administrator Signature: _____ **Date:** _____