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 ☐ 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 the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
• Polysorbate			
• A previous dose of COVID-19 vaccine			
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, polysorbate, or any vaccine or injectable medication? This would include food, pet, 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?			

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists

Cumberland County Health Department
COVID-19 Vaccine Administration Record

Person being Vaccinated MUST complete ALL information in this Highlighted Box and SIGN and DATE below in order to receive the COVID-19 Vaccine

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Mailing Address: _____ City: _____ ZIP: _____

Phone Number: _____

"I have read or have had explained to me the information about COVID-19 and the COVID-19 Vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the COVID-19 Vaccine and ask that the Vaccine be given to me or to the person named below for whom I am authorized to make this request.

I understand the Health Department is authorized to use the information gained during treatment to bill me, or any other potential sources of reimbursement, such as government programs in which I am enrolled, for qualified services.

I hereby acknowledge that I was given a *COVID-19 Vaccination Record Card* from the Health Department."

Signature of person to receive Vaccine or person authorized to make the request (parent or guardian):

X_____ Date: _____

DO NOT WRITE BELOW THIS LINE: For CCHD Use Only

Clinic/Office Address: Cumberland County Health Department 200 South Indiana Toledo, IL 62468

1st Dose	**2nd Dose**
Date Vaccine Given:	**Date Vaccine Given:**
Vaccine Manufacturer: Moderna _____0.50 mL Dose	**Vaccine Manufacturer: Moderna _____0.50 mL Dose**
Lot #: _____ **Expiration Date: _____**	**Lot #: _____** **Expiration Date: _____**
Site of Injection: L or R Deltoid Thigh	**Site of Injection: L or R Deltoid Thigh**
Injection given IM without complication. **Current VIS, or CDC COVID-19 Information, given to Client/Guardian.**	**Injection given IM without complication.** **Current VIS, or CDC COVID-19 Information, given to Client/Guardian.**
Vaccination Administered by: **_____**	**Vaccination Administered by:** **_____**

Medicare ***Part B#*:** _____ Medicaid#: _____

Private Insurance: ID#: _____ Group#: _____