WAIMĀNALO HEALTH CENTER

Prevaccination Checklist for COVID-19 Vaccines

Patient Name:_____ **DOB**:_____

Age:_____***IF ages 12-17, please complete Pfizer consent form. If ages 5-11, please complete other consent/checklist.**

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 questions, 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.

Screening Questionnaire: please circle response below

1. Are you feeling sick today? *If Yes, please call back to schedule when the illness has improved. If patient has current COVID-19 infection, patient will need to call back after isolation is over.*	**Yes**	**No**	**Don't know**
2. Have you ever received a dose of COVID-19 vaccine? **a. If yes, which vaccine product did you previously receive?** Pfizer Moderna Janssen (Johnson & Johnson) Another product_____ **b. Where? _____** **c. Date of dose 1_____** **d. Date of dose 2_____** **e. Date of dose 3_____** **f. Did you bring your vaccination record card or other documentation?** Yes No *Pfizer booster has been approved for ages **12+**. Moderna booster has been approved for ages **18+.** You can receive an mRNA booster at least **5** months after your primary vaccine series of Pfizer, **6** months after your primary vaccine series of Moderna, or at least **2** months after your J&J vaccine.*	**Yes**	**No**	**Don't know**
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? (This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant (HCT), DiGeorge syndrome or Wiskott-Aldrich syndrome)	**Yes**	**No**	**Don't Know**

*****Give completed forms in Vaccine Clinic cabinet for Rachel. If applicable attach Pfizer consent for 12-17 y/o.*

Updated 01/05/2022 LZ. Based off of CDC Prevaccination Checklist for COVID-19 vaccines updated 12/02/2021.

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	A Third Dose of Pfizer or Moderna is for people with moderately to severely compromised immune systems that can be administered at least 28 days after the second dose of Pfizer or Moderna. Please note this is different than a booster dose.			
4.	**Have you received a hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?** *CT and CAR-T-cell recipients who received doses of COVID-19 vaccine prior to receiving an HCT or CAR-T-cell therapy should be revaccinated with a primary vaccine series at least 3 months (12 weeks) after transplant or CAR-T-cell therapy.*	**Yes**	**No**	**Don't Know**
5.	**Have you ever had an allergic reaction to (see list below):** (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.) *If yes to any of the below, STOP and do not proceed. Vaccine is contraindicated.*			
	a. 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	**Yes**	**No**	**Don't know**
	b. Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	**Yes**	**No**	**Don't know**
	c. A previous dose of COVID-19 vaccine	**Yes**	**No**	**Don't know**
6.	**Have you ever had a severe allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?** *If yes, patient will be observed for 30 minutes after vaccination.*	**Yes**	**No**	**Don't know**
7.	**Have a history of myocarditis or pericarditis?** *People who develop myocarditis or pericarditis after a first dose of an mRNA COVID-19 vaccine should defer receiving the second dose. If patient has a history of myocarditis or pericarditis unrelated to mRNA COVID-19 vaccination, may receive any FDA-authorized COVID-19 vaccine after episode has completely resolved.*	**Yes**	**No**	**Don't know**
8.	**Check all that apply to you:** □ **Am a female between ages 18 and 49 years old** □ **Am a male between ages 12 and 29 years old** □ **Have a severed allergic reaction to something other than a vaccine or infectable therapy such as food, pet, venom, environmental or oral medication allergies** *(should be observed for 30 mins after vaccination)*			

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□ **Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19** *(defer 30 days if used for post-exposure prophylaxis or 90 days if used to treat COVID-19)* □ **Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection** *(consider after 90 days after diagnosis, refer to Provider for questions)* □ **Have a bleeding disorder** □ **Take a blood thinner** □ **Have a history of heparin-induced thrombocytopenia(HIT) or thrombosis with thrombocytopenia syndrome (TTS)** *(can be offered mRNA COVID-19 vaccine if >90 days since TTS resolved)* □ **Am currently pregnant of breastfeeding** □ **Have received dermal fillers** □ **History of Guillain-Barre Syndrome (GBS)**			

I, the undersigned, have read the Emergency Use Authorization for the COVID-19 Vaccination. I understand the risks and benefits associated with the COVID-19 vaccine and have had any questions satisfactorily answered. I voluntarily request that the vaccine be given to me.

Signature:_____ Date:_____

For Office Use Only:

Date/time given: _____

From reviewed/Administered by:_____ Observed for 15 minutes/30 minutes. Pt Initials:_____

Vaccine Dose: 1 2 3(Pfizer or Moderna) Booster (Pfizer 0.3mL or Moderna 0.25mL)
**can only puncture Moderna vial 20 times*

Site: RD LD Vaccine Name/Lot #/Expiration/Dose/Route: **Place Sticker Here*

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