ADMIN NURSE: _____

Moderna
Pfizer
Janssen

COVID-19 VACCINATION SCREENING QUESTIONS

Public Health
Prevent. Promote. Protect.

Instructions: Fill out the following questionnaire as clearly as possible. Fill out one form per one person. Form must be completely filled out.

VACCINE DOSE: ☐ **FIRST** ☐ **SECOND** DATE: _____ CURRENT TIME: _____

FIRST NAME: _____ LAST NAME: _____

CELL PHONE: _____ EMAIL: _____

(Please initial): _____ I AM 18 YEARS OF AGE AND OLDER
Under 18 years of age, parent must sign consent on question 9 below

BIRTHDATE: _____

SEX: M or F RACE: _____ ETHNICITY: _____

COUNTRY OF BIRTH: _____

ADDRESS: _____ ZIP CODE: _____

CITY: _____ STATE: _____ COUNTY: _____

JOB TITLE: _____

PLACE OF EMPLOYMENT: _____

CHECK ONE OF THE FOLLOWING ANSWERS

	Yes	No	
1. Are you currently pregnant or breastfeeding?	☐	☐	
2. Have you received convalescent plasma in the past 3 months?	☐	☐	
3. Have you received monoclonal antibodies in the past 3 months?	☐	☐	
4. Have you been diagnosed with COVID-19 in the past?	☐	☐	
○ **When:**			
5. 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?	☐	☐	
6. Did you have a severe allergic reaction after receiving a COVID-19 Vaccine?	☐	☐	☐ **I have not yet received the Vaccine**
7. Have you received any other vaccinations in the past 14 days?	☐	☐	
8. Have you ever had a severe allergic reaction after receiving another vaccine or another injectable Medication	☐	☐	

9. I *(PLEASE SIGN)* _____ authorize to consent for vaccination for the patient named above who is at least 12 years of age.

10. Vaccine Arm: _____(LEFT OR RIGHT)