Prevaccination Checklist for COVID-19 Vaccination

For vaccine recipients (both children and adults):

The following questions will help us determine if there is any reason COVID-19 vaccine cannot be given today. If you answer “yes” to any question, it does not necessarily mean the vaccine cannot be given. It just means additional questions may be asked. If a question is not clear, please ask the healthcare provider to explain it.

1. How old is the person to be vaccinated? 
   - Yes
   - No
   - Don’t know

2. Is the person to be vaccinated sick today?
   - Yes
   - No
   - Don’t know

3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?
   - Yes
   - No
   - Don’t know
   - If yes, which vaccine product was administered?
     - Pfizer-BioNTech
     - Janssen (Johnson & Johnson)
     - Moderna
     - Novavax
     - Other
     - How many doses of COVID-19 vaccine were administered?

   - Did you bring the vaccination record card or other documentation?

4. Is the person to be vaccinated have a health condition or undergoing treatment that makes them moderately or severely immunocompromised? This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant (HCT), or moderate or severe primary immunodeficiency.
   - Yes
   - No
   - Don’t know

5. Is the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?
   - Yes
   - No
   - Don’t know

6. Has the person to be vaccinated 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 caused hives, swelling, or respiratory distress, including wheezing.)
   - Yes
   - No
   - Don’t know
   - A component of a COVID-19 vaccine
   - A previous dose of COVID-19 vaccine

7. Has the person to be vaccinated 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 caused hives, swelling, or respiratory distress, including wheezing.)
   - Yes
   - No
   - Don’t know

8. Check all that apply to the person to be vaccinated:
   - Yes
   - No
   - Don’t know
   - Have a history of myocarditis or pericarditis
   - Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
   - History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
   - Have a history of thrombosis with thrombocytopenia syndrome (TTS)
   - Have a history of Guillain-Barré Syndrome (GBS)
   - Have a history of COVID-19 disease within the past 3 months?
   - Vaccinated with monkeypox vaccine in the last 4 weeks?

Form reviewed by __________________________ Date __________________________

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists
1st / 2nd Shot - Pfizer Monovalent

I hereby give my consent to the healthcare provider at University Health Services to administer the Covid-19 vaccine. I have read or had explained to me the Emergency Use Authorization (EUA) for the Pfizer or Johnson & Johnson vaccine I am about to receive and understand the risks and benefits.

Pfizer Bivalent Booster

I, the undersigned, wish to receive the Pfizer COVID 19 BIVALENT BOOSTER vaccine. I understand that the Food and Drug Administration amended the emergency use authorization (EUA) for the Pfizer-BioNTech COVID-19 Bivalent Vaccine to allow for use of a single booster dose, to be administered at least two months after completion of the primary series or last booster dose, OR at least three months since the last positive Covid-19 test. By signing this form, I attest that I meet at least one of the criteria defined by the CDC to determine eligibility. I hereby certify that the foregoing answers to the health questions are true and complete to the best of my knowledge. I understand that a “YES” response to any of the health questions above may require that a University Health Services provider talk with me prior to getting the Pfizer COVID 19 Bivalent BOOSTER. I understand the benefits and risks of the Pfizer COVID 19 Bivalent BOOSTER vaccine and had the chance to ask questions. I have been advised to remain on site for 15 minutes after receiving the vaccine. For any reaction to a previous COVID-19 vaccination, I have been advised to stay for 30 minutes.

I understand that the information regarding myself and the services I receive will be entered into Oklahoma State Immunization Information System.

Patient Signature:_________________________________________ Date:_____________________

Date of Birth:______________________________________________

Address:____________________________________________________

________________________________________________________________________

________________________________________________________________________

Vaccine Manufacturer/Lot #/Exp. Date: (Provider circle one)

Monovalent:  
PFIZER  LOT# FR2583  
EXP  DATE 6/30/2023  
SITE LT____ RT____

Bivalent:  
PFIZER LOT# GH9694  
EXP DATE 12/31/2023  
SITE LT____ RT____