# Prevaccination Checklist for COVID-19 Vaccination

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 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.

**Name**

<table>
<thead>
<tr>
<th>Age</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
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1. Are you feeling sick today?  

2. Have you ever received a dose of COVID-19 vaccine?  
   - If yes, which vaccine product(s) did you receive?  
     - [ ] Pfizer-BioNTech  
     - [ ] Moderna  
     - [ ] Janssen  
     - [ ] Another Product  
     
   • How many doses of COVID-19 vaccine have you received?  
   
   • Did you bring your vaccination record card or other documentation?  

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)

4. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?

5. 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 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 and preparations for colonoscopy procedures  
     - Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids  
   • A previous dose of COVID-19 vaccine

6. 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 caused hives, swelling, or respiratory distress, including wheezing.)

7. Check all that apply to you:
   - [ ] Am a male between ages 12 and 39 years old  
   - [ ] Have a bleeding disorder  
   - [ ] Have a history of myocarditis or pericarditis  
   - [ ] Take a blood thinner  
   - [ ] Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection  
   - [ ] Have a history of Guillain-Barré Syndrome (GBS)

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

02/25/2022  
Date
I, the undersigned, wish to receive the Pfizer COVID 19 BOOSTER vaccine. I understand that the Food and Drug Administration amended the emergency use authorization (EUA) for the Pfizer-BioNTech COVID-19 Vaccine to allow for use of a single booster dose, to be administered at least six months after completion of the primary series. 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 BOOSTER. I understand the benefits and risks of the Pfizer COVID 19 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:

PFIZER LOT#   FL3197
EXP DATE 6/30/2022
SITE   LT____ RT____