Prevaccination Checklist for COVID-19 Vaccination

Name _____

For vaccine recipients:

Banner ID # (CWID) _____

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. How old are you? _____			
2. Are you feeling sick today?	☐	☐	☐
3. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product(s) did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	☐	☐	
4. Do you have a health condition or are you undergoing treatment that makes you 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.*	☐	☐	☐
5. Have you received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. 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	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. 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.)*	☐	☐	☐

8. Check all that apply to you:

- ☐ 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?

Form reviewed by _____ **Date** _____

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

☐ 1st / 2nd Shot

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.

☐ Booster

Pfizer COVID 19 BOOSTER vaccine

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 five months after completion of the primary series, and a second booster dose, to be administered at least four months after the first booster to adults ages 50 years and older and people who are moderately or severely immunocompromised. 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____