Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Name _____

Age _____

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. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• Have you received a complete COVID-19 vaccine series *(i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna])*?	☐	☐	
• Did you bring your vaccination record card or other documentation?	☐	☐	
3. 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:			
o Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
o Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
4. 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.)*	☐	☐	☐

5. 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 history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré Syndrome (GBS)

Form reviewed by _____ **Date** _____

COVID-19 Mass Vaccination Form

For documentation in RPMS EHR

Use of form is not necessary if documenting vaccine in RPMS EHR at point of service
Use of form is optional based on determined local workflow

Section I: PATIENT or PATIENT REPRESENTATIVE to complete this section

Date:	Last Name (Print):	First Name (Print):	Middle Name (Print):

Date of Birth:	Chart Number (if known):	Allergies/Adverse Drug Reactions: ☐ NONE

COVID Vaccine dose: ☐ 1st dose ☐ 2nd dose ☐ 3rd dose ☐ Booster dose	If 2nd/3rd/booster dose, enter date and facility of previous dose(s):
	COVID-19 Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS) received? ☐ Yes ☐ No

Section II: To Be Completed By HEALTHCARE PROFESSIONAL Administering Vaccine

Patient meets requirement for COVID-19 immunization per CDC and ACIP recommendations/guidelines?
☐ Yes ☐ No

Prevaccination Checklist for COVID-19 Vaccines reviewed and vaccination administration deemed appropriate?
☐ Yes ☐ No ☐ Precaution identified and vaccination in an alternate setting needed

Immunization site: ☐ Right Deltoid ☐ Right Thigh (peds) ☐ Left Deltoid ☐ Left Thigh (peds)

☐ **Moderna**	☐ 1st dose **0.5mL**	☐ 3rd dose for immunocompromised individuals **0.5mL**
18 years and older	☐ 2nd dose **0.5mL**	☐ Booster dose for **18 years** and older **0.25mL ← NOTE DOSE of 0.25mL**
☐ **Pfizer**	☐ 1st dose **0.3mL**	☐ 3rd dose for immunocompromised individuals Pfizer **0.3mL**
12 years and older	☐ 2nd dose **0.3mL**	☐ Booster dose for **18 years** and older **0.3mL**

☐ **Pfizer: Pediatrics 5 to less than 12 years** ☐ 1st dose (5 to < 12 years) **0.2mL** ☐ 2nd dose (5 to < 12 years) **0.2mL**

☐ **Janssen: 18 years and older** ☐ 1st dose **0.5 mL** ☐ Booster dose **0.5 mL**

Lot Number:	Expiration:	Administration time:	Date of Vaccine Information Statement (VIS) or Emergency Use Authorization (EUA) Fact Sheet:

Administration notes:

☐ **Vaccine literature provided** Education duration (minutes): _____
☐ **Information given on benefits, side effects, post immunization care** Education duration (minutes): _____
☐ **Provided information on following the required schedule for vaccinations** Education duration (minutes): _____
Level of Understanding: ☐ Good ☐ Fair ☐ Poor **Readiness to Learn:** ☐ Receptive ☐ Other:
Comments:

Assessment after injection: ☐ Patient left before assessment completed ☐ Patient assessed after 15 minutes ☐ No reaction noted ☐ Patient assessed after 30 minutes (history of anaphylaxis or reactions) ☐ No reaction noted	Return Date (if applicable): ☐ COVID vaccination documentation completed in EHR

_____ _____
Signature and Title of Vaccinator **Date**