COVID-19 VACCINE: PRE-SCREENING TOOL

PATIENT NAME: _____ **DOB**:_____ **AGE:**_____

HEALTH CARD NUMBER: _____

FAMILY PHYSICIAN: _____

CLINIC DATE/LOCATION: _____

SCREENER NAME/DESIGNATION: _____

FIRST OR SECOND DOSE OF VACCINE? ☐ First Dose ☐ Second Dose

Which vaccine did you receive for your first dose: ☐ Pfizer ☐ Moderna ☐ Astra Zeneca

	YES	NO	NOTES
Do you have any symptoms of COVID-19, or do you feel ill today?			
Have you had an anaphylactic reaction or a reaction within 4 hours to the COVID-19 vaccine before?			
Do you have a known allergy or hypersensitivity to polyethylene glycol, polysorbate or any ingredients to the vaccine?			
Have you received a vaccine in the past 14 days?			
Are you or could you be pregnant or breastfeeding?			
Do you have a weakened immune system or are you taking any medications that can weaken your immune system (e.g., high dose steroids, chemotherapy)?			
Do you have an autoimmune condition? (i.e. Rheumatoid Arthritis, Lupus)			
Are you currently on any blood thinners? (i.e. aspirin, warfarin)			
Have you received any blood products in the last 24-48 hours? (e.g. monoclonal antibodies, convalescent plasma, human immunoglobulin)			
Have you ever felt faint or fainted after receiving a vaccine or medical procedure?			
Do you consent to receiving the vaccine?			
Have you tested positive for COVID 19 in the last 90 days?			

Post vaccine waiting time determined by listed factors: □ 15 min □ 30 min

If you have any questions or concerns, please contact your healthcare provider to review prior to receiving vaccine.

_____ _____

Patient Printed Name Patient Signature