COVID-19 Vaccine Pre-Screening Form

Please complete the following questionnaire prior to receiving your vaccine.

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
1. Are you feeling sick or do you have a fever today?	◯	◯
2. Have you ever received a dose of COVID-19 vaccine?	◯	◯

If yes, which vaccine product did you receive?

◯ Pfizer ◯ Moderna ◯ Another product _____

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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)		
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	◯	◯
• Polysorbate	◯	◯
• 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)		
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	◯	◯
6. Have you received any vaccine in the last 14 days?	◯	◯
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	◯	◯
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	◯	◯
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	◯	◯
10. Do you have a bleeding disorder or are you taking a blood thinner?	◯	◯
11. Are you pregnant or breastfeeding (nursing)?	◯	◯

If you have answered YES to any of the above questions, please speak to a nurse before receiving the vaccine. Patients who have had any type of allergic reactions in the past will require 30 minutes of observation after the vaccine.

I have received the EUA Fact Sheet for the Moderna COVID-19 Vaccine.
I have had an opportunity to ask questions and any questions have been answered to my satisfaction.

Print Name_____ Date_____

Signature_____ Age_____