WAIMĀNALO HEALTH CENTER

Pre-vaccination Checklist for COVID-19 Vaccine – Dose 2

Patient Name:_____ **DOB**:_____ **Age:**_____**Weight:**____

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 questions, 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.

Screening Questionnaire: please circle response below

1. Are you feeling sick today? *If Yes, please call back to schedule when the illness has improved.* *If patient has current COVID-19 infection, patient will need to call back after isolation is over.*	☐ **Yes**	☐ **No**	☐ **Don't know**
2. Have you ever received a dose of COVID-19 vaccine?	☐ **Yes**	☐ **No**	☐ **Don't know**
a. **If yes, which vaccine product? Pfizer Moderna Another product_____** b. **Where? _____ c. Date of vaccine? _____** *If yes and first dose was administered elsewhere, STOP and do not proceed. Vaccine series must be completed with prior vaccine site. If first dose was administered at WHC, ok to continue if same vaccine available at WHC.*			
3. Have you ever had an allergic reaction to (see list below): (This would include a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen or that caused you to go the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) *If yes to any of the below, STOP and do not proceed. Vaccine is contraindicated.*			
a. **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**	☐ **Yes**	☐ **No**	☐ **Don't know**
b. **Polysorbate**	☐ **Yes**	☐ **No**	☐ **Don't know**
4. A previous dose of COVID-19 vaccine	☐ **Yes**	☐ **No**	☐ **Don't know**
5. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? This would include food, pet, environmental, or oral medication allergies. *If yes, inform patient he/she will be observed for 30 minutes after vaccination. If patient has questions, should be referred to Provider.* **RN: counsel patients about unknown risks vs benefits of vaccination, refer patient to Provider if further discussion needed. Observe for 30 mins after vaccination.*	☐ **Yes**	☐ **No**	☐ **Don't know**

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6. Have you received any vaccine in the last 14 days? *If yes, STOP and do not proceed. Pt can call back to schedule after 14 days have passed from last vaccine.*	☐ **Yes**	☐ **No**	☐ **Don't know**
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you have COVID-19? *If yes and recovered and completed isolation, ok to schedule. If patient has current COVID-19 infection, will need to call back after isolation is over.*	☐ **Yes**	☐ **No**	☐ **Don't know**
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19? *If yes, STOP and do not proceed. Vaccination should be deferred for at least 90 days since treatment.*	☐ **Yes**	☐ **No**	☐ **Don't know**
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? *If yes, ok to schedule. If patient has questions, should be referred to Provider.* **RN: counsel patients about unknown risks vs benefits of vaccination, refer patient to Provider if further discussion needed.*	☐ **Yes**	☐ **No**	☐ **Don't know**
10. Do you have a bleeding disorder or are you taking blood thinner? *If yes, ok to schedule. If patient has questions, should be referred to Provider.* **RN: use fine gauge needle (23 gauge or smaller), followed by firm pressure on the site, without rubbing, for at least 2 minutes.*	☐ **Yes**	☐ **No**	☐ **Don't know**
11. Are you pregnant or breastfeeding? *If yes, ok to schedule, but if patient has questions, should be referred to Provider.*	☐ **Yes**	☐ **No**	☐ **Don't know**

I, the undersigned, have read the Emergency Use Authorization for the COVID-19 Vaccination. I understand the risks and benefits associated with the COVID-19 vaccine and have had any questions satisfactorily answered. I voluntarily request that the vaccine be given to me.

Signature:_____ **Date**:_____

For Office Use Only:

Date/time given: _____

Vaccine Name/Lot #/Expiration/Dose/Route:
**Place Sticker Here*

Vaccine Dose: 1 2 Site: RD LD
Administered by:_____ Observed for 15 minutes/30 minutes. Pt Initials:_____