WAIMĀNALO HEALTH CENTER

Prevaccination Checklist for COVID-19 Vaccines

Patient Name:_____ **DOB**:_____

Age:_____***IF ages 12-17, please complete Pfizer consent form**

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** ☐	☐

a. If yes, which vaccine product did you previously receive?

☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product_____

b. Where? _____

c. Date of dose 1_____

d. Date of dose 2_____

If 2-dose series was completed elsewhere, ok to receive 3rd dose at WHC, if eligible, but must bring vaccination card.
If they received J&J, not eligible for a second or third dose.

e. Has it been at least 28 days since the second dose of Pfizer or Moderna vaccine?

☐Yes ☐No *(if No, will need to wait until it has been at least 28 days since 2nd dose)*

f. Check all that apply to you *(If none apply, then do not need a 3rd dose at this time)*

- ☐ Been receiving active cancer treatment for tumors or cancers of the blood
- ☐ Received an organ transplant and are taking medicine to suppress the immune system
- ☐ Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
- ☐ Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- ☐ Advanced or untreated HIV infection
- ☐ Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response

*****Give completed forms to Tanya in IT. If applicable attach Pfizer consent for 12-17 y/o.*

Updated 8/23/21 LZ. Based off of CDC Prevaccination Checklist for COVID-19 vaccines updated 8/20/2021.

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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 to 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, which is found in some vaccines, film coated tablets, and intravenous steroids	**Yes** ☐	**No** ☐	**Don't know** ☐
c. A previous dose of COVID-19 vaccine	**Yes** ☐	**No** ☐	**Don't know** ☐
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 rection that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing. *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** ☐
5. Had COVID-19 and was treated with monoclonal antibodies or convalescent serum as a treatment for COVID-19? *If yes and at least 90 days since treatment, ok to schedule. Vaccination should be deferred for at least 90 days since treatment.*	**Yes** ☐	**No** ☐	**Don't know** ☐
6. Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?	**Yes** ☐	**No** ☐	**Don't know** ☐

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If yes, should refer patient to Provider prior to scheduling. Consider delaying vaccine until recovery from infection and 90 days after date of diagnosis.			
7. Have a history of myocarditis or pericarditis? *If yes, should refer patient to Provider. People who develop myocarditis or pericarditis after a first dose of an mRNA COVID-19 vaccine should defer receiving the second dose.* *If patient has a history of myocarditis or pericarditis unrelated to mRNA COVID-19 vaccination, may receive any FDA-authorized COVID-19 vaccine after episode has completely resolved.*	**Yes** ☐	**No** ☐	**Don't know** ☐
8. 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** ☐ **Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies** *(30 min observation)* ☐ **Have a weakened immune system (i.e., HIV infection, cancer)** ☐ **Take immunosuppressive drugs or therapies** ☐ **Have a bleeding disorder** ☐ **Take a blood thinner** ☐ **Have a history of heparin-induced thrombocytopenia(HIT)** ☐ **Am currently pregnant of breastfeeding** ☐ **Have received dermal fillers** ☐ **History of Guillain-Barre Syndrome (GBS)**	**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: _____

From reviewed/Administered by:_____ Observed for 15 minutes/30 minutes. Pt Initials:_____

Vaccine Dose: 1 2 3 Site: RD LD

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

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