2nd appt____ Immuniz registry ____ VaxTrax ____ Walk-in ____ Just in Time ____

PREVACCINATION CHECKLIST FOR COVID-19 VACCINES

Print Name: _____ Date of Birth: _____

Age: _____ Email: _____ Phone: _____

Questions for person receiving vaccine	Yes	No
1. Are you sick today? (fever, cough, vomiting in the last 24 hours)		
2. Are you currently in isolation for COVID-19 or have you been in close contact with someone who tested positive for COVID-19 in the past 14 days?		
3. Have you received a dose of the Covid-19 vaccine?		
• If YES, what manufacturer? Pfizer Moderna other		
4. Have you received any vaccines in the past 14 days?		
5. Have you received antibody therapy for convalescent plasma for COVID-19 treatment in the past 90 days?		
6. Have you ever had a severe allergic reaction (anaphylactic) to any food, medication, vaccine or previous COVID-19 vaccine?		
• If so, please list:		
7. Are you pregnant or breastfeeding?		
8. Do you have a weakened immune system caused by something such as cancer or HIV injection? Do you take immunosuppressive drugs or therapies?		
9. Do you have a bleeding disorder or are you taking a blood thinner?		

Form Reviewed by_____ Date_____

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FOR OFFICE USE ONLY

Manufacturer: Pfizer Moderna J&J Other_____

1st dose 2nd dose

Vaccination time: _____ Site: Left Right

Lot Number: _____ Expiration: _____

Name of Vaccinator: (Print) _____

Observed for: 15 min 30 min

Cleared to leave by: (Print) _____