Public Health
Prevent. Promote. Protect.
Colusa County

Pre- Vaccination Checklist for COVID-19 VACCINES

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 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.

CAIR# : _____

Name: _____

Date of Birth: ____/____/_____ Age: _____

Gender: _____ Ethnicity: _____

Address: _____

_____

Email: _____

Phone Number: _____

Occupation: _____

Mother's First Name:_____

	Yes	No	Unkn
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Another product _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			
10. Do you have dermal fillers?			

Administered Date:	**Vaccine Administration Site:** ☐ **LD** ☐ **RD**
Lot Number:	**Vaccine route of Administration: IM**
Manufacturer:	**Administered by:**

Patient Signature: _____ Date: _____ Form Reviewed By: _____

System Entered In: _____ Initial: _____ Date: _____ FIRST DOSE ☐ SECOND DOSE ☐