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 ☐ Janssen *(Johnson& Johnson)* ☐ Another product _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to: (This includes, a severe allergic reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?			
• **A component of a COIVD-19 vaccine,** including either of the following: ○ **Polyethylene Glycol (PEG)**, found in some medications, such as laxative and preparations for colonoscopy procedures.			
○ **Polysorbate**, which is found in some vaccine, film coated tablets and, intravenous steroids.			
• **Receiving a previous dose of COVID-19 vaccine**			
4. Have you ever had an allergic reaction to another vaccine or an injectable medication?			

5. 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
☐ Have a history of myocarditis or pericarditis
☐ Taken immunosuppressive drugs or therapies
☐ Have a bleeding disorder
☐ Take a blood thinner
☐ Am currently pregnant or breastfeeding
☐ Have received dermal fillers
☐ Have a history of heparin-induced thrombocytopenia (HIT)
☐ Have a weakened immune system (i.e., HIV infection, cancer)
☐ Had COVID-19 and treated with monoclonal antibodies or convalescent serum
☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
☐ Have had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies.

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

Patient Signature (**or Parent**): _____ Date: _____ Form Reviewed By: _____
System Entered In: _____ Initial: _____ Date: _____ FIRST DOSE ☐ SECOND DOSE ☐