Public Health
Prevent. Promote. Protect.
Colusa County

Pre-Vaccination Checklist for COVID-19 Vaccine

Name: _____
Date of Birth: ____/____/_____ Age: _____
Gender: _____ Ethnicity: _____
Street: _____
City: _____ State: _____ Zip Code: _____

Email: _____
Phone Number: _____
Mother's First Name: _____

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.

	Yes	No	Unkn
1. Are you feeling sick today?	☐	☐	☐
2. Have you tested positive for COVID-19 within the past 3 months?	☐	☐	☐
• If yes, what is the approximate date of the positive result? _____			
3. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Janssen *(Johnson& Johnson)* ☐ Another product _____			
• How many Doses of the COVID-19 Vaccine have you received? _____			
• When did you receive your **last** dose? _____ (MM/DD/YY)			
4. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)*	☐	☐	☐
5. Have you received a COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. Have you ever had a severe allergic reaction to a component of a COVID-19 vaccine? *(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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐
7. Have you ever had a severe allergic reaction after receiving a previous dose of COVID-19 vaccine? *(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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

Continue questions on the back page

	Yes	No	Unkn
8. Have you ever had an allergic reaction to another vaccine or an injectable medication?	☐	☐	☐

9. Check all that apply to you:

☐ Have a history of myocarditis or pericarditis
☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)
☐ Have a history of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin induced thrombocytopenia (HIT)
☐ Have a history of thrombosis with thrombocytopenia (TTS)
☐ Have a history of Guillain- Barré Syndrome (GBS)

Patient Signature: _____ Date: _____
(18 or older)

If minor:

Print Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

Official Use Only:

Form Reviewed By: _____ ☐ FIRST DOSE ☐ SECOND DOSE ☐ BOOSTER # _____

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

County of Colusa DHHS: Public Health Division

CAIR #: _____ Initial: _____ Date: _____