Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name _____

Age _____

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	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product _____			
3. Have you ever had an allergic reaction to: (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.)			
• A component of a COVID-19 vaccine including either of the following:			
○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
• A previous dose of COVID-19 vaccine.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
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 reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Form reviewed by _____ **Date** _____

CHAMPIONS *for* HEALTH
PHYSICIANS IMPROVING HEALTH CHANGING LIVES

County of San Diego

Immunization Registration Form
(Forma para registro de vacunas)
إستمارة التسجيل للتلقيح

Event Site:
Champions for Health
Date:

PLEASE PRINT PATIENT'S INFORMATION / الرجاء كتابة معلومات المريض
FAVOR DE IMPRIMIR LA INFORMACION DEL PACIENTE

LAST NAME/APELLIDO/ اللقب	FIRST NAME/PRIMER NOMBRE/ الإسم الأول	MIDDLE INITIAL/INICIAL/ الإسم الوسطي

DATE OF BIRTH / FECHA DE NACIMIENTO/ تاريخ الولادة	AGE/EDAD/ العمر	GENDER/GENERO/ الجنس
MONTH/MES / DAY/DIA / YEAR/AÑO *If under age 18, parental consent required (indicate below)		☐ MALE MASCULINO ذكر ☐ FEMALE FEMENINO أنثى ☐ NON-BINARY NO BINARIO

RACE/RAZA/أصل	ETHNICITY/ETNICIDAD/الأصل العرقي	OCCUPATION/OCUPACIÓN/عمل
☐ AMERICAN INDIAN/ ALASKAN NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN/PACIFIC ISLANDER ☐ OTHER RACE ☐ ASIAN ☐ WHITE ☐ UNKNOWN ☐ DECLINE	☐ HISPANIC/LATINO ☐ NON HISPANIC/LATINO ☐ UNKNOWN/DECLINE	☐ FIRST RESPONDER PERSONAL DE PRIMER CONTACTO ☐ HEALTHCARE WORKER TRABAJADOR DE SALUD ☐ LONG TERM CARE FACILITY STAFF PERSONAL EN UN CENTRO DE CUIDADOS DE LARGO PLAZO ☐ OTHER (specify): OTRO (ESPECIFICAR)

HOME/MOBILE PHONE/TELEFONO / رقم هاتف المنزل	EMAIL/CORREO ELECTRÓNICO	
( ) AREA CODE/LADA/ رمز المنطقة		

☐ UNSHELTERED ☐ SHELTERED	STREET ADDRESS/CALLE Y NUMERO/ عنوان الشارع	CITY/CIUDAD المدينة	STATE/ESTADO الولاية	ZIP CODE/ZONA POSTAL/ الرمز البريدي

Have you received immunizations during the last 12 months? هل أخذت أية لقاحات في الإثنى عشر شهر الماضية؟	☐ YES / نعم	☐ NO/ لا
Ha recibido vacunas aquí durante los últimos 12 meses?	☐ SI	☐ NO

A. I have been given a copy and have read, or have had explained to me, the information in the specific Vaccine Information Statement(s) about the disease(s) and the vaccine(s) which will be given today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and the risks of the vaccine(s) and allow this (these) vaccine(s) checked below to be given to me or to the person for whom I am authorized to make this request.

B. I understand that the patient's name, other identifying information and immunization history may be shared with other licensed health providers, e.g., physicians, nurses, hospitals, etc. and schools for the purpose of immunization management and I consent to the release of this information, unless I have indicated that I do not wish for my record to be shared by making a checkmark in the column labeled "SDIR Decline to Share."

A. Me han dado una copia y he leido, o me han explicado, la información contenida en la Declaración de Información de vacunas sobre las enfermedades y vacunas indicadas abajo. He tenido oportunidad de hacer preguntas, las que me han sido contestadas a mi completa satisfacción. Creo que entiendo los beneficios y los riesgos de las vacunas y pido que esta(s) vacuna(s) indicadas abajo sean aplicadas a mi or a la persona que nombre aparece abajo, por quien estoy autorizado/a para hacer esta solicitud.

B. Entiendo que el nombre del paciente y otra información de identificación, asi como la historia de vacunación pudiera ser compartida con otros proveedores de salud con licencia, por ejemplo otros médicos, enfermeras, hospitales, etc. y escuelas para propósitos de manejo de las vacunas y que yo estoy de acuerdo que esta información sea compartida, a menos de que yo haya indicado que no deseo permitir que mis datos sean compartidos marcando la columna "SDIR Decline to Share."

SIGNATURE/FIRMA/التوقيع	DATE / FECHA/التاريخ	SDIR Decline to Share (only check if declining to share)/Negarse a compartir/رفض المشاركة
		☐

PARENT NAME (If under age 18)	PARENT PHONE	

OFFICE USE ONLY BELOW

Vaccine Given (Brand Name)	Lot #	Expiration Date	Site	
			LD	RD
			LD	RD
			LD	RD
			LD	RD

VIS Print Date: 12/20/2020 **VIS given (initials):**

VACCINATOR Name (print):	Sign:	SDIR #:

SDIR Data Entry Completed by	Name:	Date: