

Patient's Name \_\_\_\_\_

DOB \_\_\_\_\_

### Covid Vaccine Screen

Please Circle

- |  |     |    |
|--|-----|----|
| 1. Is the person to be vaccinated sick today?  | Yes | No |
| 2. Did the person to be vaccinated today have anaphylaxis to previous COVID vaccine? (Which vaccine type?)   | Yes | No |
| 3. Did the person to be vaccinated today have an allergic reaction to a COVID vaccine within 4 hours of vaccination? (Which vaccine type?) * this does not include soreness, redness, swelling injection site reactions. It does not include fever, headache, fatigue, body aches, abdominal complaints. | Yes | No |
| 4. Did the person to be vaccinated today have a serious reaction after Receiving any vaccine? * this does not include soreness, redness, swelling injection site reactions. It does not include fever, headache, fatigue, body aches, abdominal complaints.  | Yes | No |
| 5. Did the person to be vaccinated today have Allergy to PEG?  | Yes | No |
| 6. Did the person to be vaccinated today have myocarditis or pericarditis, due to previous COVID vaccine (within 3 weeks)?   | Yes | No |
| 7. Did the person to be vaccinated today have myocarditis, pericarditis, Or MIS-C due to a previous COVID infection or viral infection?  | Yes | No |
| 8. Does the person being vaccinated today have cancer, HIV or is immunosuppressed?   | Yes | No |
| 9. Did the person to be vaccinated today have dizziness or fainting after vaccinations in the past?  | Yes | No |