



## Bureau of Infectious Disease Control

### Pre-Vaccination Screening Questions for Persons 5-17 Years of Age Receiving the Pfizer-BioNTech COVID-19 Vaccine

The following questions will help us determine if there is any reason your child should not get the COVID-19 vaccine. If you answer “yes” to any of the questions, it does not necessarily mean your child should not be vaccinated. It just means additional information may be needed. Please answer the questions below for your child who is receiving the vaccine.

Name of Person Receiving the Vaccine: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

	Yes	No	Don't Know
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever received a dose of a COVID-19 vaccine before? <b>If yes</b> , which COVID-19 vaccine product(s) were you previously given? <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Did you have an allergic reaction after a prior dose of any COVID-19 vaccine? (Allergic reactions can include symptoms like rash, hives, swelling of the face or mouth, wheezing and difficulty breathing, etc.) <b>If yes</b> , please specify the specific vaccine AND your allergic reaction: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a known allergy to an ingredient in the Pfizer-BioNTech COVID-19 vaccine? (See the provided age-appropriate FDA Fact Sheet for a list of vaccine ingredients)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have a known allergy to polyethylene glycol (PEG)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have a known allergy to polysorbate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had any allergic reaction within 4 hours of receiving a non-COVID-19 vaccine or other injectable medication (including medications injected into a muscle, vein, or under the skin)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had a severe allergic reaction (like anaphylaxis) due to any other cause, including to medications taken by mouth, food, or other substances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Did you develop myocarditis or pericarditis after receiving a prior dose of either the Pfizer-BioNTech or Moderna COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have a bleeding disorder or are you taking blood thinners?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. In the last 90 days, have you been given a COVID-19 antibody therapy to either treat COVID-19, or to prevent COVID-19 from developing after you were exposed to another person with COVID-19? (Antibody therapies include monoclonal antibodies or a blood product called “convalescent plasma”)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please sign below to confirm that the information on this form is accurate to the best of your knowledge:

Signature of Parent/Legal Guardian: \_\_\_\_\_

Printed Name of Parent/Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_



## Bureau of Infectious Disease Control

## Pre-Vaccination Screening Questions for Persons 18 Years of Age or Older

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine. If you answer "yes" to any of the questions, it does not necessarily mean you should not be vaccinated. It just means additional information may be needed. Please answer the questions below for the person who is receiving the vaccine.

Name of Person Receiving the Vaccine: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

COVID-19 Vaccine Being Administered: ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen (Johnson & Johnson)

	Yes	No	Don't Know
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever received a dose of a COVID-19 vaccine before? <u>If yes</u> , which COVID-19 vaccine product(s) were you previously given? <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Did you have an allergic reaction after a prior dose of any COVID-19 vaccine? (Allergic reactions can include symptoms like rash, hives, swelling of the face or mouth, wheezing and difficulty breathing, etc.) <u>If yes</u> , please specify the specific vaccine AND your allergic reaction: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a known allergy to an ingredient in the COVID-19 vaccine that you will be receiving today? (See the provided FDA Fact Sheet for a list of vaccine ingredients)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have a known allergy to polyethylene glycol (PEG)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have a known allergy to polysorbate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had any allergic reaction within 4 hours of receiving a non-COVID-19 vaccine or other injectable medication (including medications injected into a muscle, vein, or under the skin)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had a severe allergic reaction (like anaphylaxis) due to any other cause, including to medications taken by mouth, food, or other substances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Did you develop myocarditis or pericarditis after receiving a prior dose of either the Pfizer-BioNTech or Moderna COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have a bleeding disorder or are you taking blood thinners?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. In the last 90 days, have you been given a COVID-19 antibody therapy to either treat COVID-19, or to prevent COVID-19 from developing after you were exposed to another person with COVID-19? (Antibody therapies include monoclonal antibodies or a blood product called "convalescent plasma")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. In the last 90 days, did you develop an immune-related health condition that caused blood clotting AND low platelet blood counts? (The most common example of this is called "heparin-induced thrombocytopenia")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Did you develop a health condition called "thrombosis with thrombocytopenia" (TTS) after receiving a prior dose of the Janssen vaccine? (People with this syndrome develop blood clotting and low platelet blood counts after receiving the Janssen vaccine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Did you develop Guillain-Barré syndrome (GBS) after receiving a prior dose of the Janssen vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please sign below to confirm that the information on this form is accurate to the best of your knowledge:

Signature of Vaccine Recipient: \_\_\_\_\_

Date: \_\_\_\_\_