**Internal Use Only:** 1 2 3

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| **What to Bring to Appointment:**   * **Completed COVID-19 Vaccine Screening Form** * **Vaccine Card (if this is a 2nd dose or booster dose)** |  |

# COVID-19 Vaccine Screening Form

**Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **M.I:** \_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Age:** \_\_\_\_\_\_ **Phone Number:** (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_ **Gender Assigned at Birth:** Male Female

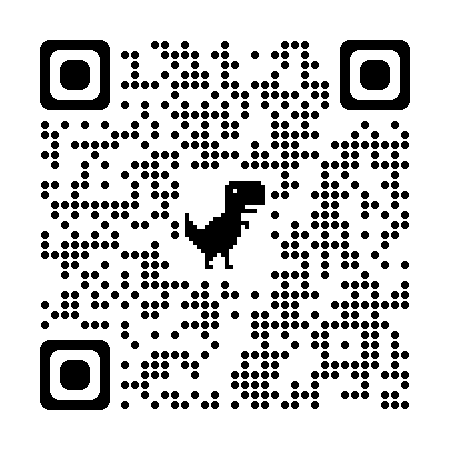
**Race:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Emergency Contact Name and Phone#:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**State:** \_\_\_\_\_\_\_\_**Zip Code:** \_\_\_\_\_\_\_\_\_\_\_

**Please answer the following questions: 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.

|  |  |  |  |
| --- | --- | --- | --- |
| Are you feeling sick today? | YES | NO |  |
| Have you ever received a dose of Pfizer COVID-19 vaccine? How many doses? 1 2 3 | YES | NO |  |
| Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital? | YES | NO |  |
| Was the severe allergic reaction after receiving a COVID-19 vaccine or any other vaccine or injectable medication? | YES | NO |  |
| Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? | YES | NO |  |
| Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a Covid-19 infection? | YES | NO |  |
| Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? | YES | NO |  |
| Are you a male between the ages of 12 and 29 years old and have a history of myocarditis or pericarditis? | YES | NO |  |
| Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? | YES | NO |  |
| Do you have a bleeding disorder or are you taking a blood thinner? | YES | NO |  |
| Do you have a history of Guillain-Barre Syndrome? | YES | NO |  |
| Are you pregnant or breastfeeding? | YES | NO |  |
| I acknowledge that I have read or had explained to me the Emergency Use Authorization Fact Sheet for the following COVID-19 vaccine. I have also had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described. I request that the COVID-19 vaccine be given to me or to the person named above for whom I am authorized to make this request.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_  Signature (**if under 18, must be signed by parent/guardian**) Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed name of parent/guardian if under 18 | | | |
| **For Internal Use Only:**  Injection Site: LA RA  **Pfizer 12+ Lot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pfizer Ages 5-11 Lot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Provider Name, Signature and Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

**Information for Vaccine Recipients**



**For more information on the Pfizer Covid-19 Vaccine for ages 5-11:**

Scan the QR code or to get to the Fact Sheet for Recipients and Caregivers: www.cvdvaccine.com

**For more information on the Pfizer 12+ COVID-19 Vaccine:**

Scan the QR code or to get the Fact Sheet for Recipients and Caregivers: www.cvdvaccine.com