Regional Medical Center

Public Health
Prevent. Promote. Protect.
Delaware County Public Health

Regional Family Health

(Last) _____ (Maiden) _____ (First) _____

(Middle) _____ DOB: _____/_____/_____ (age) _____

Phone Number: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Healthcare Provider: _____

Insurance Name: _____ Policy Number: _____

Policy Holder Name: _____ Policy Holder DOB: _____/_____/_____

Insured Policyholder Employer: _____

COVID-19 Pre-Vaccination Assessment: 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.

	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) **Date vaccine received**: _____			
• Did you bring your vaccination record card or other documentation?			
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 caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of the 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			
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 caused hives, swelling, or respiratory distress, including wheezing.)			
5. Check all that apply to you:			
❑ I am a female between ages 18 and 49 years old			
❑ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies			
❑ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum			
❑ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection			
❑ Have a weakened immune system (i.e., HIV infection, cancer)			
❑ Take immunosuppressive drugs or therapies			
❑ Have a bleeding disorder			
❑ Take a blood thinner			
❑ Have a history of heparin-induced thrombocytopenia (HIT)			

Check all that apply to you:			
❏ Am currently pregnant or breastfeeding			
❏ Have received dermal fillers			
	YES	**NO**	**DON'T KNOW**
6. Will you follow the recommended post-vaccination observation time? (15 or 30 min)			

Consent: I have read or have had explained to me the information provided in the Emergency Use Authorization (EUA) Factsheet or Vaccine Information Statement about COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be administered to me or the person named above for whom I am authorized to make this request.

Signature ____ **Date** ________________

Legal Guardian Signature ____ **Date** ________________

Print Name______________________________________ **Relationship to Patient**_________________________

**********************************STAFF USE ONLY**********************************

Date Administered	Vaccine Manuf.	Vaccine Lot #	Exp. Date	Fact Sheet date	Dose	Site	Administered By:
___/___/___					0.5ml	**Right** **Left** Deltoid	

REACTION: ☐ NO ☐ YES ____

IRIS Entered: Initial ________ Date ________ Time ________

BILLING:
☐ CL0011A (MODERNA 1ST DOSE) ☐ CL0012A (MODERNA 2ND DOSE)
☐ CL0001A (PFIZER 1ST DOSE) ☐ CL0002A (PFIZER 2ND DOSE)
☐ CL0031A (JANSSEN)