Total Health Care

COVID-19 Vaccine Screening Questionnaire and Consent
2020-2021

SECTION 1 PLEASE PRINT CLEARLY

Last Name | First Name | MI | Birth Date | Age

Street Address | Apt. # | City | State | Zip Code

Telephone # | E-Mail

(**Circle one in each category below**)

Sex: M F **Race**: African-American Asian/Pacific Islander American Indian/Alaska Native White Other **Hispanic:** Y / N

Consent for Vaccination:

In signing this form, I understand the benefits and risks of the Coronavirus vaccine and give permission for me or the person for whom I am legally responsible to receive the vaccine. Further, I agree that: (1) The information provided is correct; (2) I have read or have had explained to me the Vaccine Information Statement (EUA); and, (3) Any questions I had about the vaccine(s) have been answered. I have had a chance to ask questions that were answered to my satisfaction.

Signature of person to receive vaccine or person legally authorized to give consent: X _____

Date: _____

SECTION 2: CONTRADICTIONS & PRECAUTIONS

1. Have a fever, difficulty breathing, dry cough, sore throat, or other Coronavirus symptoms today **or** in the past week?	**Y / N**
2. Have you or a close household member tested positive for Coronavirus in the last two weeks?	**Y / N**
3. Have you received passive antibody treat (monoclonal antibodies or convalescent plasma) as part of CoVID-19 treatment within the last 90 days?	**Y / N**
4. Have you ever had a severe allergic reaction (e.g., anaphylaxis) after a previous dose of an mRNA CoVID-19 vaccine, or following any previous vaccination or injectable therapy (i.e., intramuscular, intravenous, or subcutaneous vaccines of therapies) not related to a component of mRNA CoVID-19 vaccines?	**Y / N**
5. Have you ever had an immediate allergic reaction of any severity to any component of the CoVID-19 vaccine including polyethylene glycol (PEG) or polysorbate? [A complete list of Vaccine components is listed on the EUA]	**Y / N**
6. Received other Coronavirus vaccination(s)? If yes, **Dose #1 Date:** **Mfgr:**	**Y / N**
7. Received other vaccination(s) in the past 2 weeks?	**Y / N**
8. Have a long-term health condition such as cancer; diabetes; heart disease (not hypertension); lung disease (asthma, COPD); kidney/ liver disease; Anemia/Sickle Cell disease/other blood disorder; neurologic or neuromuscular disease (seizures, palsy); or, history of fainting (syncope)?	**Y / N**
9. Do you have a bleeding disorder or are you taking a blood thinner?	**Y / N**
10. Do you have a weakened immune system from HIV/AIDS or another disease? Do you take long-term treatment with high-dose steroids; or cancer treatment with radiation / drugs?	**Y / N**
11. Are you pregnant? Are you breastfeeding (nursing)?	**Y / N**

Screener Signature: _____ Date: _____

VACCINE ADMINISTRATION

Vaccine Type	**Pfizer**
Dose / Route	0.5 ml/ IM
Site	☐ Right Deltoid ☐ Left Deltoid
Lot #	EW0164
Nurse's Notes	
EUA Date	12/2020

Signature/ Title of Administrator Date