COVID-19 Vaccine Screening Questionnaire and Consent
2020-2022

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/Black White Other:_____ **Hispanic:** Y / N **Language:** English Other:_____

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:

1. Do you have a fever, difficulty breathing, dry cough, sore throat, or other Coronavirus symptoms today **or** in the past week?	**Y / N**	**VACCINE ADMINISTRATION**	
2. Have you or a close household member tested positive for Coronavirus in the last two weeks?	**Y / N**	**Vaccine Type**	**Pfizer**
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**	**Dose / Route**	0.3 ml/IM
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**	**Site**	☐ Right Deltoid ☐ Left Deltoid
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**	**Nurse's Notes**	
6. Have you received previous Coronavirus vaccination(s)? If yes, **Dose 1:** Date: Mfgr: **Dose 2:** Date: Mfgr:	**Y / N**		
7. Do you have health insurance? If yes, please provide copy of insurance card or write in information here: Not required if insurance information submitted in past six months	**Y / N**		
8. For 3rd Doses Only: 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**	**Lot #**	
		EUA Date	12/2020

Screener Signature:_____ Date:_____

Administrator Signature:_____ Date:_____