CHOC Primary Care Network Consent and Screening Checklist for COVID- 19 Vaccine
For Children, Teens and Adults 2021-2022

_____ _____/_____/_____ _____
PRINT NAME of person receiving vaccine Date of Birth Age

_____
Address City State Best Contact Number
(Address required for adult non-patients only)

_____
Mother's First Name (Required for adult non-patients only)

_____
PLEASE ANSWER THE FOLLOWING QUESTIONS (please check):

1. Are you feeling sick today or have had a fever of 100.4 in the last 24 hours? ☐Yes ☐No
2. Have you ever received a dose of COVID-19 vaccine? ☐Yes ☐No
   - If yes which vaccine product did you receive?
     ☐Pfizer ☐Moderna ☐Janssen (Johnson & Johnson) ☐Another Product
   - Did you bring your vaccination record card or other documentation? ☐Yes ☐No
3. 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 a 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? ☐Yes ☐No
     - Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids? ☐Yes ☐No
   - A previous dose of COVID-19 vaccine? ☐Yes ☐No
   - An allergic reaction to another vaccine or injectable medication? ☐Yes ☐No
4. **Check all that apply to you:**
   - ☐ 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)
   - ☐ Am currently pregnant or breastfeeding
   - ☐ Have received dermal fillers

ACKNOWLDEGEMENT:

1. I have been given and read or have had explained to me the information in the federal Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers for the vaccine that will be administered today.
2. I have had a chance to ask questions which were answered to my satisfaction.
3. I understand the benefits and risks of the Pfizer-BioNTech COVID-19 vaccine and I am consenting to receive the Pfizer-BioNTech COVID-19 vaccine injection.

_____ _____/_____/_____ _____
Signature of person consenting to vaccine Date Time

_____ _____
Printed Name of person consenting to vaccine Relationship to patient

_____ _____/_____/_____ _____
If applicable, form reviewed and approved by (Name & Title) Date Time

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Nursing Documentation: (Use this section for adult non-patients)

Temperature: _____ Infrared/tat/po/ax (Do not vaccinate if temperature ≥ 38ºC)

☐ Reviewed attached screening and consent form. If any questions has a "yes" response, the provider must be notified to decide to clear the patient to receive the vaccine. Except for 2nd Pfizer BioNTech COVID Vaccine administration.

☐ Provide recipient the current Fact Sheet for Recipients and Caregivers Emergency Use Authorization (EAU) of The Pfizer-BioNTech COVID-19 vaccine.

☐ **Vaccine**: Pfizer-BioNTech COVID-19 vaccine: **Manufacturer**: Pfizer BioNTech

Lot #: _____ Expiration Date: ____/____/_____ ☐**First Dose** ☐**Second Dose**

IM Site: ☐Deltoid, Left ☐Deltoid, Right ☐Other: _____

_____ _____
Signature & Credentials Administered By Printed Name Administered By

____/____/_____ _____
Date Given Time

CAIR Documentation:
Vaccine Administration Transcribed: ☐Yes _____
Signature & Credentials