Receiving Today (Circle one): *First Dose *Second Dose *Third Dose *Booster Dose		
BRANCH HILLSDALE ST. JOSEPH COMMUNITY HEALTH AGENCY COVID-19 VACCINATION FORM		
Last name:	**Maiden or other name:**	**First name:**
Gender at birth:	**DOB:**	**Age:**
Street Address:		**Phone:**
City:	**State:**	**Zip Code:**
Race: (Please circle one option) ***White *Black/African-American *Asian *Chinese *Japanese** ***Filipino *Arab *Alaskan Native *American Indian/Alaskan Native** ***Native Hawaiian/Other Pacific Islander *Native Hawaiian *Other Race *Unknown**		**Ethnicity: (Please circle one option)** ***Unknown** ***Hispanic/Latino** ***Not Hispanic/Latino**

Pre-vaccination Checklist for Covid-19 Vaccines

1. Are you feeling sick today? **Yes ☐ No ☐ Don't know ☐**

2. Have you ever received a dose of COVID-19 vaccine? **Yes ☐ No ☐ Don't know ☐**

If yes, which product?
Pfizer-BioNTech ☐
Moderna ☐
Johnson & Johnson (Janssen) ☐
Another Product ☐ _____

- Have you received a complete COVID-19 vaccine series? **Yes ☐ No ☐**
  - (i.e., 1 dose of Janssen or 2 doses of Pfizer or Moderna)
- Did you bring your vaccination record card or other documentation? **Yes ☐ No ☐**

3. Have you ever had an allergic reaction with hives, swelling within 4 hours of exposure, respiratory distress or wheezing that required an injection of epinephrine (EpiPen), admission to an emergency room or hospital due to:

- A component of the COVID-19 vaccine due to polyethylene glycol (PEG) or **Yes ☐ No ☐ Don't know ☐**
- Polysorbate (emulsifiers used in some pharmaceuticals and food preparations) **Yes ☐ No ☐ Don't know ☐**
- A previous dose of COVID-19 vaccine **Yes ☐ No ☐ Don't know ☐**

4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? **Yes ☐ No ☐ Don't know ☐**

5. Check all that apply to you:

- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Received a hematopoietic cell transplant (HCT) or CAR-T-cell therapy since receiving Covid-19 vaccine
- ☐ Have a health condition or undergoing treatment that makes you moderately or severely immunocompromised
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ History of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ History of Guillain-Barré Syndrome (GBS)

_____ _____ _____

Name (Print) **Signature** **Date**

By signing I certify that the answers to the above questions are true to the best of knowledge, I have reviewed and received the vaccine information and I give consent to receive the vaccine from BHSJ CHA.

Please explain any "YES" answers from the questions here:

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Covid-19 Vaccine (Circle One) **Pfizer 12+ (0.3 mL)** **Pfizer 5-11 (0.2 mL)** **Moderna (0.5 mL)** **Moderna Booster (0.25 mL)** **Janssen (0.5 mL)**	**LOT Number:** _____	**VIS Literature-NA (EUA Fact Sheet)**	**Injection Site:** **SITE: LD☐ RD☐**

By signing, I certify that the patient in question has been given vaccine information and that any and all applicable questions and forms were answered and reviewed prior to vaccine administration.

_____ _____ _____

Nurse Signature **Date** **Time**