Prevaccination Checklist for COVID-19 Vaccination

For vaccine recipients:

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 it.

Name _____

Age _____

	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(s) did you receive?			
☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	☐	☐	
3. Check all that apply:	☐	☐	☐
☐ I live in a long-term care setting.			
☐ I have been diagnosed with a medical condition(s). Please list: _____			
☐ I am a first responder.			
☐ I work in a long-term care facility, correctional facility, hospital, restaurant, retail setting, school, or other setting with high exposure to the public.			
4. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)*	☐	☐	☐
5. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	☐	☐	☐
6. 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 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	☐	☐	☐
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐

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	Yes	No	Don't know
7. 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.)*	☐	☐	☐

8. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ 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
- ☐ Have a history of Guillain-Barré Syndrome (GBS)

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists

Student Health Services
DIVISION OF STUDENT AFFAIRS

Website: shs.tamu.edu
Appointments: (979) 458-8310

COVID-19 Vaccination Registration Consent Form

Information Statement: Please check off the following statements:
☐ I have been given a copy and have read the COVID-19 VACCINE FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA).
☐ I understand the Moderna / Pfizer vaccines require two doses. Two doses will need to be administered for the vaccine to be effective.
☐ I have been given a chance to ask questions which were answered to my satisfaction.
☐ I understand the benefits and risks associated with this vaccine; I am requesting that the vaccine be given to me.
☐ I acknowledge that I have been instructed to remain at the vaccination location for a minimum of 15 minutes for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
Signature of Person to Receive Vaccine: X _____ Date Signed: _____

FOR VACCINATOR TO COMPLETE

Date Vaccine Administered: _____ **Time**: _____

Vaccine Manufacturer:

☐ **Janssen**	☐ First Dose	☐ Additional Dose	☐ Booster	
☐ **Moderna**	☐ First Dose	☐ Second Dose	☐ Additional Dose	☐ Booster (Half Dose)
☐ **Pfizer**	☐ First Dose	☐ Second Dose	☐ Additional Dose	☐ Booster

Vaccine Lot Number: _____ **Expiration Date of Vaccine**: _____

Site of Injection: (IM)
☐ Left Deltoid ☐ Right Deltoid

Patient to complete observation:
☐ 15 minutes ☐ 30 minutes

Signature and Title of Vaccine Administrator:

X_____

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). THE EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.