## Pre-Vaccination Checklist for COVID-19 Vaccines

Immunizer name (print):



\_ Date:\_

	se print clearly.			last n	ame:					
nate of hirth:	_	Age:	Gender:	□ Female	□ Male	Phone:				
tate:	ZIP code:	Er	nail address:							
	mber or Medicare Nu									
	F									
☐ Other Race	ndian or Alaska Native		□ Unknown		Islander	□ Black or	African Amer	ican □ Whit	te	
	ic or Latino	oanic or Latino			onths o	r more sii	nce your la	st dose: 「	<b>∀es</b>	□ No
	following questions will he						nee your id		_ 103	
Do you feel sick to								☐ Yes		□ Don't kn
	agnosed with or tested po				02			☐ Yes		□ Don't kn
	ys have you been identific cieved a dose of COVID-1		ontact to someone t	vitri COVID-1	9!			☐ Yes		□ Don't kn
	story of allergic reaction o		ntex, medications for	ood or vaccine	es (exampl	es: polvethy	lene alvcol.			□ Don't kr
polysorbate, eggs If yes, please list:	s, bovine protein, gelatin,	gentamicin, po	olymyxin, neomycin,	phenol, yeas	t or thime	rosal)?	3170017			_ 50.11 C KI
	d a reaction after receiving	ng a vaccination	n, including fainting	or feeling diz	zy?			☐ Yes		□ Don't kr
Do you have Derr								☐ Yes		□ Don't kr
Have you received any vaccinations or skin tests in the past eight weeks?  If yes, please list:  Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take									□ Don't kı	
	eakened immune system ove drugs or therapies?	caused by some	_			-			⊔ No	□ Don't kı
. Do you have a ble	eeding disorder or are you	ı taking a bloo	d thinner?					☐ Yes	□ No	□ Don't kr
. For women: Are y	ou pregnant or consideri	ng becoming p	regnant in the next	month?				☐ Yes	□ No	□ Don't kr
. Have you been tr	eated with antibody thera	py specifically	for COVID-19 (mon	oclonal antibo	odies or co	nvalescent p	lasma)?	☐ Yes	□ No	☐ Don't kr
	sible to predict all possible side effectione(s) I have elected to receive. I all d remain near the vaccination located	so acknowledge that tion for observation f visions, affiliates, sub	t I have had a chance to asl or approximately 15 minut sidiaries, officers, directors,	questions and that es after administra	at such questio	ons were answere f ofthepatient,the	ed to my received, sa epatient's heirs and p	tisfaction. Further, personal represent	I acknowle atives, I he own arising	edge that I have b reby release and I
vised that the patient should rmless each applicable Provoth, or in any way related to thate HIE"); and (b) the applich as state, county, or local Education, for purposes of public heastate-approved opt-out formate Registry; or (b) the State lovide me with an Opt-Out Form, I E, as applicable. I understant permitted by law. I further concent of the comment Agencies to mouse the payment be ofbenefit thorized coinsurance and due at the time of service or, ing the contact information	rider, its staff, agents, successors, divine administration of the vaccine(s) cable Provider may disclose my vacce pepartments of Health or the federalth reporting, or to my healthcare on the staff of	cination information al Department of He providers enrolled in no pt-out form ("Opt ing my vaccination in on my state's law, I no may HIE the orthromain in effect until il consent, my state's I. e Provider to: (a) relere, Medicaid, or othe sible Provider with re and services, as well me after the time of:	to the State Registry, to the alth and Human HiEtother. In the State Registry and/or sout Form" furnished by the State Registry and/or sout Form" furnished by the state Registry and souther southern the state Registry and	nd the purposes/bustate HIE, or throu- pegistry,orto Service- gistry,orto Service- state HIE for purpo- te applicable Provi- with the healthcare pr d, to the extent required try to the entities and that I may with hit certain disclosumation, including a ssary to effectuate ed items and servi- and services not continuous. Pharmac- centinuous. Pharmac-	enefits of my s  igh the StateS  is, the Centers  ses of care cor  der: (a) the dis  oviders enrolle  uired by my st  and for the pu  draw my consures of my vacc  or, communic  care or payme  ces. I further a  overed by my i  y or its affiliate	tate's vaccination tateany state or for for Disease Contr for Disease Contr closure of my vac ed in the State Re- ate's law, by signi poses described ent by providing ination informati able disease (incli ent; (b) submit a cogree to be fully fin surance benefit sr may contact you	registry ("State Reg ederal governmenta ol and Prevention, c owledge that, deper cination information gistry and/or State I- ng below, I hereby c in this Informed Cor a completed Opt-O ion to or through the uding HIV)and mentalaim to my insurer f inancially responsib s. I understand that. u, including by auto	istry") and my state lagencies or autho- tr their respective or ding upon my sta by the applicable IE. The applicable to consent to the a sent form. Unless I it Form to the appl e State HIE or to Go al health information the above reque e for any cost-shai any payment for w dialed and prereco	orities ("Goodesignees a te's law, I n Provider to pplicable P provide th licable Provovernment ion, to, or the ested items ring amour hich I am fi orded calls a	nformation excha vernment Agenci. s may be require nay prevent, by u: the State HIE an II, if my state perr rovider reporting e applicable Prov vider and/or my S Agencies as requ hrough, the State and services; an ants, including cop nancially respons and texts, at any ti
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