Pre-Vaccination Checklist for COVID-19 Vaccines

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.

Patient 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? ☐ Pfizer ☐ Moderna ☐ Another product _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

Form reviewed by _____ **Date** _____

COVID-19 Mass Vaccination Form

For documentation in RPMS EHR

Use of form is not necessary if documenting vaccine in RPMS EHR at point of service
Use of form is optional based on determined local workflow

Section I: PATIENT or PATIENT REPRESENTATIVE to complete this section

Date:	**Last Name** (Print):	**First Name** (Print):	**Middle Name** (Print):

Date of Birth:	**Chart Number** (if known):	**Allergies/Adverse Drug Reactions:** ☐ **NONE**

COVID dose:	**If 2nd dose:**	**If 2nd vaccine dose, manufacturer of 1st dose:**	**If 2nd dose, note if there were any unexpected reactions to 1st dose:**
☐ 1st dose ☐ 2nd dose	Date of 1st dose:	☐ Moderna ☐ AstraZeneca ☐ Novavax ☐ Pfizer ☐ Johnson&Johnson ☐ Sanofi Pasteur ☐ Other:	

Section II: To Be Completed By HEALTHCARE PROFESSIONAL Administering Vaccine

Patient meets requirement for COVID-19 immunization per CDC and ACIP recommendations/guidelines?
☐ Yes ☐ No

COVID-19 Vaccine Screening Questionnaire reviewed and vaccination administration deemed appropriate?
☐ Yes ☐ No

COVID-19 Vaccine Manufacturer:	**Lot Number:**	**Injection volume:**
☐ Moderna ☐ AstraZeneca ☐ Novavax ☐ Pfizer ☐ Johnson&Johnson ☐ Sanofi Pasteur ☐ Other:		☐ 0.3mL ☐ 0.5mL

Immunization site:	**Vaccine Information Statement (VIS) or Emergency Use Authorization (EUA) Fact Sheet Date:**	**Administration time:**
☐ Right Deltoid ☐ Right Thigh (peds) ☐ Left Deltoid ☐ Left Thigh (peds)		

Administration notes:

☐ **Vaccine literature provided** Education duration (minutes): _____
☐ **Information given on benefits, side effects, post immunization care** Education duration (minutes): _____
☐ **Provided information on following the required schedule for vaccinations** Education duration (minutes): _____
Level of Understanding: ☐ Good ☐ Fair ☐ Poor **Readiness to Learn:** ☐ Receptive
Comments: ☐ Other:

Assessment after injection:	**Return Date** (if applicable):
☐ Patient left before assessment completed ☐ Patient assessed after 15 minutes ☐ No reaction noted	☐ COVID vaccination documentation completed in EHR

_____ _____

Signature and Title of Vaccinator **Date**

Instructions for Completing
COVID-19 Mass Vaccination Form for documentation in RPMS EHR

Purpose of form:

1. Capture patient vaccine information during mass vaccination events, off-site vaccination events, or during other times when it is not feasible to capture vaccination at the point of service
2. Use of form is not necessary if vaccine administration is captured in RPMS EHR at the point of service

Form instructions:

1. Print legibly in all fields using dark permanent ink
2. Section I, to be completed by PATIENT or PATIENT REPRESENTATIVE
3. Section II, to be completed by HEALTHARE PROFESSIONAL who administers vaccine
4. Information from form is to be electronically recorded in RPMS EHR