Prevaccination Checklist For COVID-19 Vaccine
Custom Prescriptions of Lancaster, LLC

Patient Information

Name _____ **Date of Birth** _____

Addess _____ **Phone Number** _____

Gender ☐**Male** ☐**Female** ☐**Other**

Race ☐**African American** ☐**American Indian** ☐**Asian** ☐**Native Hawaiian/Pacific Islander** ☐**Hispanic** ☐**White** ☐**2 or More Race**

Physician Name _____ **Phone Number** _____

INSURANCE ID _____ **RxGRP** _____ **RxBIN** _____ **Rx PCN** _____ **Medicare Part B** _____

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 shoud be vaccinated.**

1. Are you feeling sick today?	**Yes**	**No**	**Unsure**
2. Have you ever received a dose of COVID-19 vaccine?	**Yes**	**No**	**Unsure**
• If yes, which vaccine product did you receive? ☐Pfizer ☐Moderna ☐Another product _____			
3. 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	**Yes**	**No**	**Unsure**
• Polysorbate	**Yes**	**No**	**Unsure**
• A previous dose of COVID-19 vaccine	**Yes**	**No**	**Unsure**
4. 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	**Yes**	**No**	**Unsure**
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	**Yes**	**No**	**Unsure**
6. Have you received any vaccine in the last 14 days?	**Yes**	**No**	**Unsure**
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	**Yes**	**No**	**Unsure**
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	**Yes**	**No**	**Unsure**
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	**Yes**	**No**	**Unsure**
10. Do you have a bleeding disorder or are you taking a blood thinner?	**Yes**	**No**	**Unsure**
11. Are you pregnant or breastfeeding?	**Yes**	**No**	**Unsure**

I have received the current Vaccine Information Statement(s) for the requested vaccine(s) and have read or have had explained to me the information about the requested vaccine. I certify that I am (i) the patient and at least 18 years old, (ii) the parent or legal guardian of the minor party, or (iii) the legal guardian of the patient and hereby give my consent to administer the vaccine requested above. I understand and agree that I will not be able to sue the physician who approved the protocol or the pharmacy for any injury or property damage I may suffer as a result of the immunization.

Patient/Guardian Signature _____ **Date** _____