Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name ____________________

Age __________

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.

	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 did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ 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 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.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
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.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
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?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Form reviewed by ____________________ **Date** ____________

ADULT PATIENT REGISTRATION FORM FOR COVID 19 VACCINE CLINICS

LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTH DATE	AGE

MAILING ADDRESS	EMAIL ADDRESS

CITY	STATE	ZIP	COUNTY 051

HOME PHONE	CELL PHONE	Social Security Number

Marital Status M / S / W / P / D   Sex M / F   Language: ❑ English ❑ Spanish ❑ Other

Race: ❑ Asian ❑ Black ❑ American Indian /Alaskan Native ❑ White ❑ Hawaiian/Pacific Islander ❑ Other

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Other

VACCINE REQUESTED:

☐ **COVID VACCINE DOSE #1 (VIS Date 12/2020) English / Spanish (unavailable)**

☐ **COVID VACCINE DOSE #2 (VIS Date 12/2020) English / Spanish (unavailable)**

☐ Group 1 ☐ Group 2 ☐ Group 3 ☐ Group 4 ☐ Group 5

Employer or LTCF

PAYOR :

☐ MEDICARE PART B # ______________________________

☐ MEDICAID # ____________________________________

☐ INSURANCE NAME & POLICY # ________________________________

☐ SELF PAY $_________________________   (NPI 1528157211) Insurance Purposes

PATIENT CONSENT/ASSIGNMENT OF BENEFITS/RELEASE FOR TPO

- **The Notice of Privacy Practices describes how Johnston County Health Department may use or disclose information about you. Johnston County is required to give you notice of our privacy practices for the information we collect and keep about you. I have been given a copy of Johnston County's Notice of Privacy Practices and have been informed about the intent of the document. I also understand that if I have questions concerning this document I will be provided opportunity for further explanation upon request.**
- **I have read or have had explained to me information about the above listed immunizations, vaccines, or injections. I have received a copy of the VIS statement & I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the listed immunizations, vaccines, or injections, and request that they be administered to me or to the person named above for whom I am authorized to make this request.**
- **I request that payment of authorized Insurance Companies and/or Payor's, should I receive these services, be made to Johnston County Public Health Department for providing the Covid 19 Vaccine.**

Patient/Guardian Signature______________________________________ **Date** ________________

I, do hereby swear that I am 18 years or older and have given consent to Johnston County Public Health Department to administer the above vaccine and have given my verbal consent for this registration form to be signed on my behalf.

Verbal Consent by: ________________________ Witness: ____________________ **Date** ______________

Relationship: ____________________________

ALLERGIES:	**VACCINE PREPARED BY**

IMM/VACCINE/INJECTION	INJECTION SITE	MANUFACTURER/LOT NO.	VACCINE ADMIN BY
COVID 19 VACCINE **Z23 / 91301 Moderna Z23 / 91300 Pfizer** **Z23 / 91303 Johnson & Johnson**	**L - R DELT**		

Updated 04/5/2021) ☐ CVMS ☐ Immu. Cmd Vaccine Admin Fees: Moderna 1st 0011A 2nd 0012A

Vaccine Admin Fees: Pfizer 1st 0001A 2nd 0002A

Vaccine Admin Fees: J & J 0031A