HEALTHY DAVIS TOGETHER

CommuniCare HEALTH CENTERS
a california health+ center

County of Yolo
Founded 1850

Screening Questionnaire for COVID-19 Vaccines

(Complete for each person receiving a vaccination.)

Each patient must complete this form to be vaccinated. The following questions will help us determine if there is any reason we should not give you a COVID-19 vaccination today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask clinic staff to explain it.

Please answer the following questions. Mark **YES** or **NO**:

1. **Are you feeling sick today?** YES ☐ NO ☐

2. **Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product?** YES ☐ NO ☐
   - ☐ Pfizer-BioNTech
   - ☐ Moderna
   - ☐ Janssen/Johnson and Johnson

3. **Have you ever had an allergic reaction to any of the following? If yes, which one(s)?** YES ☐ NO ☐
   (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
   - ☐ Polysorbate
   - ☐ A previous dose of COVID-19 vaccine

4. **Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?** YES ☐ NO ☐
   (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, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.** YES ☐ NO ☐

6. **Have you received any vaccine in the last 14 days?** YES ☐ NO ☐

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 ☐

8. **Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?** YES ☐ NO ☐

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 ☐

10. **Do you have a bleeding disorder or are you taking a blood thinner?** YES ☐ NO ☐

11. **Are you pregnant or breastfeeding?** YES ☐ NO ☐

Personal Information for COVID-19 Vaccines

(Complete for each person receiving a vaccination.)

Each patient must complete this form to be vaccinated. The information on this form should be filled in for the person receiving the vaccination today. A separate form should be used for each member of your family if multiple people are receiving the vaccine today.

Please print clearly.

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Sex/Gender:

☐ Male ☐ Female ☐ Prefer not to answer

Date of Birth (MM/DD/YYYY): _____

Race:

☐ American Indian or Alaska Native ☐ Black or African American ☐ White

☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other

Ethnicity:

☐ Hispanic or Latino ☐ Other

Phone: _____ **Email:** _____

Address: _____

City: _____ **Zip:** _____

Occupation: _____

How did you hear about the clinic today?

☐ Website ☐ Newspaper ☐ Other

☐ Social Media ☐ Flyer

My signature below indicates that (please sign at the clinic):

- I have read or had explained to me the "Emergency Use Authorization of the **Janssen,** Moderna or Pfizer BioNTech COVID-19 Vaccine" (EUA).
- I had an opportunity to ask questions which were answered to my satisfaction.
- I believe I understand the benefi ts and risks of COVID-19 vaccine and request that it be given to me or to the person for whom I am authorized to make the request.
- I have been provided with a copy of the Notice of Privacy Practices.
- I have answered the questions on the next page to the best of my ability.
- I understand that my vaccination record will be kept in the California Immunization Registry (CAIR) database.

Signature **Today's Date** **Relationship of Guardian**