PUBLIC HEALTH SOLUTIONS COVID-19 VACCINE SCREEING FORM
PFIZER COVID 19 VACCINE

The following questions will help decide if there is any reason you should NOT receive COVID-19 vaccine today. Answering "yes" to any question does not mean you should not get vaccinated. It means you may be asked more questions. If you do not understand a question, ask you healthcare provider to explain it.

Date: _____ Patient Name: _____ DOB: _____ Age: _____ Gender: F / M

Maiden Name _____ Parent Name (if patient is a minor): _____

Address: _____ Town: _____ Zip Code: _____

Phone Number: _____ Doctor's Name: _____

All questions must be answered.

1. Are you sick today?	Yes / No
2. Have you ever received a dose of COVID-19 vaccine?	Yes / No
3. If yes, which vaccine did you receive? a. Pfizer b. Moderna c. Other _____ d. Not applicable.	
4. Have you ever had a severe allergic reaction to anything? For example, a reaction for which you were treated with an EpiPen or for which you were hospitalized?	Yes / No
5. If yes, was the severe allergic reaction to after getting a vaccine or another injectable medicine?	Yes / No
6. Have you had COVID-19 **infection** in the last 90 days?	Yes / No
7. Have you received antibody therapy for treatment of COVID-19 in the last 90 days?	Yes/ No
8. Are you breastfeeding, pregnant or planning to get pregnant in the next 30 days?	Yes / No
9. Have you been diagnosed with Multisystem Inflammatory Syndrome after COVID-19 infection?	Yes / No
10. Do you have a weakened immune system due to disease or treatment with chemo or radiation?	Yes /No
11. Do you have a bleeding disorder or take a blood thinner medication?	Yes/ No

Consent

I have been given a copy of the latest Emergency Use Authorization Fact Sheet for Pfizer COVID-19 Vaccine Recipients and Caregivers. I have read and/or have had explained to me the information on COVID-19 and the Pfizer COVID-19 vaccine. I have had the opportunity to ask questions and have those questions answered to my satisfaction. I understand the risks and benefits of vaccination against COVID-19, and I request that the Pfizer COVID-19 vaccine be given to me or the person named above for whom I am authorized to make this request. I understand and agree that Public Health Solutions is not responsible for any adverse reactions that may occur and that it is my responsibility to seek medical attention for my child or myself should an adverse reaction occur.

Patient/Parent Signature: _____
(If patient is a minor, parent signature is required.)

Date: _____

Manufacturer: Pfizer Lot #: _____

Location/Route: RDIM / LDIM

Nurse Signature: _____