Prevaccination Checklist for COVID-19 Vaccination

Name _____

For vaccine recipients (both children and adults):

The following questions will help us determine if there is any reason COVID-19 vaccine cannot be given today. **If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given.** It just means additional questions may be asked. If a question is not clear, please as the healthcare provider to explain it.

	Yes	No	Don't know
1. How old is the person to be vaccinated? _____			
2. Is the person to be vaccinated sick today?	☐	☐	☐
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product was administered? ☐ Pfizer-BioNTech ☐ Janssen *(Johnson & Johnson)* ☐ Another Product ☐ Moderna ☐ Novavax _____			
• How many doses of COVID-19 vaccine were administered? _____			
• Did you bring the vaccination record card or other documentation?	☐	☐	
4. Is the person to be vaccinated have a health condition or undergoing treatment that makes them moderately or severely immunocompromised? *This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.*	☐	☐	☐
5. Is the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. Has the person to be vaccinated 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 caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. Has the person to be vaccinated 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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

8. Check all that apply to the person to be vaccinated:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months?
- ☐ Vaccinated with monkeypox vaccine in the last 4 weeks?

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists

COVID-19 VACCINATION ADMINISTRATION RECORD

Sangamon County Department of Public Health
2833 South Grand Avenue East, Springfield, IL 62703
(217) 535-3100
Tax ID #37-6002039 NPI #1164448262

Please **PRINT** information about the person to receive the vaccine:

NAME: _____ _____ _____
Last **First** **M.I.**

BIRTHDATE: _____/_____/_____ **Age:** _____ **Sex at birth:** Choose

RACE: _____ **Ethnicity:** Choose

HOME ADDRESS:_____**IL**_____
Street **City** **Zip Code**

DAYTIME TELEPHONE: (217)_____ **Emergency Number: (217)**_____

**I understand this agency is HIPAA compliant and has HIPAA information available to me upon request.*
**I have been provided with the opportunity to take a paper copy of the Vaccine Information Statement (VIS), or I may download the VIS onto my mobile device from www.cdc/vaccines/pubs/vis/vis-downloads.htm to view and I give consent to the Sangamon County Department of Public Health to administer the vaccine.*
If applicable, I give permission to the Sangamon County Department of Public Health to bill **Medicare/Medicaid/Insurance for the administration of the COVID-19 immunization.*

SIGNATURE X_____ **DATE** _____
Patient or Parent/Guardian if under 18 years of age

An administration fee will be billed to your insurance, if you have insurance. If your insurance denies the fee that we bill, you will not be billed for it.

☐ **Medicaid:** Please provide 9 digit Number:_____

☐ **Medicare:** Please provide Medicare Number:_____

☐ **Insurance:**

☐ **Aetna**	☐ **Coventry**	☐ **Meridian**
☐ **Aetna Better Health Care**	☐ **Health Alliance**	☐ **Molina**
☐ **Blue Cross/Blue Shield MCO**	☐ **HFS (SKILO)**	☐ **United Healthcare**
☐ **Blue Cross/Blue Shield PPO**	☐ **Health Alliance**	☐ **Other**_____
☐ **Cigna**	☐ **Illinicare**	☐ **None**

ID/Subscriber Number: _____ **Group Number:**_____

Site of Vaccination: **Left Deltoid** _____ **Right Deltoid** _____

Manufacturer: **Pfizer** **Lot#**_____
Moderna **Lot#**_____
Other **Lot#**_____

1st Dose _____
2nd Dose _____
3rd Dose _____
Monovalent Booster _____
Bivalent Booster _____

Provider Signature: **Date:**

PLEASE PRINT AND BRING THIS FORM TO APPOINTMENT