

Pre-vaccination Checklist

Vaccine Manufacturer:

SECOND DOSE DATE:

1. Do you have any current symptoms consistent with a COVID-19 infection?
(If **YES**, discuss with clinician prior to receiving vaccine) YES / NO

2. Have you received any vaccine within the past 14 days, or are you planning to receive a vaccine within the next 14 days?
(If **YES**, discuss with clinician prior to receiving vaccine) YES / NO

3. Have you received any passive antibody therapy (monoclonal antibodies or convalescent plasma) as part of a COVID-19 treatment within the past 90 days?
(If **YES**, discuss with clinician prior to receiving vaccine) YES / NO

4. Have you had any anaphylactic response to a component of a COVID-19 vaccine (polysorbate, polyethylene glycol)?
(If **YES**, discuss with clinician and consider referral to allergist/immunologist) YES / NO

5. Do you want to speak to a clinician prior to receiving a dose of the COVID vaccine today? YES / NO