Community Health Center, Inc.

Pre-Vaccine Questionnaire

Patient Name: _____

Date (MM/DD/YY) _____ Patient Cell Phone #: _____

Patient Date of Birth: Month:_____Day:_____Year:_____

Please answer the following questions before your vaccine appointment. If you answer "yes" to any questions, it does not necessarily mean you should not be vaccinated.

1. Are you feeling sick today? ☐ **Yes** ☐ **No**

2. Have you ever received a dose of COVID-19 Vaccine?

   ☐ **Yes, I received the Pfizer-BioNTech COVID -19 vaccine**
   ☐ **Yes, I received the Moderna COVID -19 vaccine**
   ☐ **Yes, But I don't know which COVID-19 vaccine I received**
   ☐ **No**

3. Have you ever had an allergic reaction or a severe allergic reaction to 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?

   (A severe allergic reaction includes a 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.) ☐ **Yes** ☐ **No** ☐ **I Don't Know**

4. Have you ever had an allergic reaction or a severe allergic reaction to polysorbate?
   ☐ **Yes** ☐ **No** ☐ **I Don't Know**

5. Have you ever had an allergic reaction or a severe allergic reaction to a previous dose of COVID-19 vaccine?
   ☐ **Yes** ☐ **No** ☐ **I have not received previous dose of COVID-19 vaccine**

6. Have you ever had an allergic reaction or severe allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? ☐ **Yes** ☐ **No** ☐ **I Don't Know**

7. 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** ☐ **I Don't Know**

8. Have you received a vaccine in the last 14 days? ☐ **Yes** ☐ **No**

9. Have you ever had a positive test for COVID-19 or has a doctor ever said you have COVID-19? ☐ **Yes** ☐ **No**

10. 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**

11. Do you have a bleeding disorder or are you taking a blood thinner? ☐ **Yes** ☐ **No**

12. Do you have a history of or risk factor for blood clotting disorders? ☐ **Yes** ☐ **No**

13. Are you pregnant? ☐ **Yes** ☐ **No**

14. Are you breastfeeding (nursing)? ☐ **Yes** ☐ **No**

15. Do you have any dermal fillers (a cosmetic injection to diminish facial lines and restore volume and fullness in the face)? ☐ **Yes** ☐ **No**

☐ **I have received the Emergency Use Authorization (EUA) Fact Sheet for the COVID-19 Vaccine(s). I acknowledge I have received a copy of the Privacy Policy and Terms and Conditions.**

I understand the COVID-19 vaccine has potential side effects including a remote risk of more severe or unexpected side effects. I understand that the emergency use of the COVID-19 vaccine has been authorized by the United States Food and Drug Administration (FDA) under an Emergency Use Authorization (EUA). I have read the EUA fact sheets for the vaccine that I or the person named above for whom I am the legal guardian ("Ward") may receive and understand the risks as outlined in the fact sheet. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunizations(s) by my Ward. I have had an opportunity to ask questions about this immunization. I understand my medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to me or my Ward. I, for myself and on behalf of my Ward and each of our respective heirs, executors, personal representatives and assigns, hereby release the provisioning vaccination site, and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt of my ward of this or these immunization(s). Neither the provisioning vaccination site, Community Health Center, nor any of the released parties shall, at any time or to any extent whatsoever, be liable, responsible or any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. The provisioning vaccination center may use and disclose my personal and health information or the personal and health information of my Ward, to treat me or my Ward, to receive payment of the care provided, and for other healthcare operations.

FOR PATIENTS 16 OR 17 YEARS OLD: If the individual named above is my minor child, I agree and consent to such minor receiving the COVID-19 vaccine available at the vaccination site without my presence. I understand that the vaccine requires two doses and I understand both doses must be administered at the appropriate time interval for the vaccine to be effective. I consent to the administration of both doses to my child within that time interval. I understand that my child will be asked several screening questions regarding my child's health history and current health status (the questions are attached) and I agree to review these questions with my child prior to the vaccine appointment. I further acknowledge that my child is capable of responding fully and honestly to these questions and of following all instructions provided at the time of vaccination, including the mandatory 15- or 30-minute post-vaccination monitoring period.

FOR PATIENTS 15 YEARS OLD OR UNDER: A parent/guardian or other adult designated by the parent/guardian, who is prepared toanswer the screening questions above and has parent/guardian permission to seek emergency medical treatment for the minor, MUST accompany the patient in order for the patient to receive the COVID-19 vaccine.

Name of adult accompanying the minor patient (if not parent/guardian)_____

By signing below I attest under penalty of perjury that I am 18 or older and consenting for myself or I am the legal guardian of the patient named above. I consent to receive or for my Ward to receive the COVID-19 immunization.

_____
Signature of Patient or Guardian

_____
Print Patient or Guardian: Last Name, First Name, Middle Initial

_____
Relationship to Patient (if Conservator, PoA, documentation must be provided)

_____ _____
Date Guardian Phone Number