

# Prevaccination Checklist for COVID-19 Vaccines



For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.

**If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked.

If a question is not clear, please ask your healthcare provider to explain it.

Patient Name \_\_\_\_\_

Age \_\_\_\_\_

Yes      No      Don't know

1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
<ul style="list-style-type: none"> <li>If yes, which vaccine product did you receive?  <input type="checkbox"/> Pfizer      <input type="checkbox"/> Moderna      <input type="checkbox"/> Another product _____</li> </ul>			
3. Have you 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
<ul style="list-style-type: none"> <li>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</li> </ul>			
<ul style="list-style-type: none"> <li>Polysorbate</li> </ul>			
<ul style="list-style-type: none"> <li>A previous dose of COVID-19 vaccine</li> </ul>			
4. Have you 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 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.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
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?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			

Form reviewed by \_\_\_\_\_

Date \_\_\_\_\_



TEXAS IMMUNIZATION REGISTRY (ImmTrac2) ADULT CONSENT FORM



(Please print clearly)

First Name Middle Name Last Name

Date of Birth (mm/dd/yyyy) Gender: Female Male Telephone Email address

Address Apartment # / Building #

City State Zip Code County

Mother's First Name Mother's Maiden Name

Ethnicity (Select All That apply): Race (Select Only One):

The Texas Immunization Registry is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes...

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities
I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members (older than 18 years of age) in the Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency.

Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.
I am a FIRST RESPONDER. I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) of a First Responder.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative): Printed Name
Date Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request.

Questions? (800) 252-9152 (512) 776-7284 Fax: (866) 624-0180 www.ImmTrac.com
Texas Department of State Health Services ImmTrac Group MC 1946 P. O. Box 149347 Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and affirm that consent has been granted. DO NOT fax to ImmTrac2. Retain this form in your client's record.