Prevaccination Checklist for COVID-19 Vaccines

Silicon Valley Medical Clinic, Milpitas

For vaccine recipients:

Patient Name _____

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.

Age _____ Birth Date / /

Tel: _____

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product _____			
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.)			
• A component of a COVID-19 vaccine including either of the following:			
○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
• A previous dose of COVID-19 vaccine.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
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, or any vaccine or injectable medication? This would include food, pet, venom, 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?			
12. Do you have dermal fillers?			

Form reviewed by _____ **Date** _____

04/19/2021 CS321629-E

PLEASE FLIP OVER & FILL BACK PAGE 2

ATTESTATION: Please Sign & Submit pages 1 & 2 prior to Covid-19 Vaccine Shot.

Patient Last & First Name:_____ **Date Of Birth:**_____ **Sex:**_____

Race: O Asian O African/Black O Hawaiian O American Indian O Other Race O Unknown

Occupation: _____ **Ethnicity:** O Hispanic O Non-Hispanic O Other O Unknown

1) I am 18 years of age. I am authorized to give health & demographics information on behalf of the Patient as self or a parent or a guardian. I am the individual noted above and have personal knowledge of the facts set forth herein and in patient registration form.
2) I understand that my eligibility to receive a COVID-19 vaccination at this time is based on criteria set by the Centers for Disease Control (CDC) and the California Department of Public Health (CDPH), which includes my status in paid or unpaid work in certain sectors, or certain age or medical conditions, and that only people eligible to be vaccinated under those criteria may be offered a COVID-19 vaccine. I certify that I am otherwise eligible for vaccination based on my age or medical condition and I am eligible to get vaccine per CDPH guidelines.
3) I agree to provide additional documentation upon request regarding my insurance, work/employment status, age, race, or medical condition.
4) Patient has received a copy of and have read the Covid-19 Vaccine Information Fact Sheets (VIS).
5) Patient has been advised to consult a physician prior to Covid-19 vaccination, if the patient has any vaccine or health concerns stated in CDC Prevaccination Checklist and or has Cancer, Chronic Kidney Disease, COPD, Heart Conditions, Severe obesity BMI>40, or Sickle Cell disease.
6) If there is any change in patient health status or has become sick or have been diagnosed or symptoms of Covid-19; from day of signing this form to day of getting injections; I will inform the clinic promptly prior to getting injection and request to reschedule the vaccination.
7) If Patient is unable to get vaccine on as scheduled; Patient or Guardian will inform the clinic at least a day in advance.
8) On day of vaccination; Patient will be asked for sign attestation of eligibility & health and show picture ID and employee badge. When at our clinic; you are required to wear your mask & keep social distance. Patient should wear comfortable clothing so that patient's sleeves can be rolled up quickly so that your upper arm is easily accessible. We will not be able to provide gowns or full privacy. You are expected to wait 15 minutes (or 30 minutes in if patient has a past history of past allergy) after injection. This will allow us to get the patient medical attention, if needed.
9) COVID-19 vaccination will be provided FREE to our clinic and at no cost to the patient; no matter if you are insured or non-insured or under insured. If you have an insurance, Vaccination Providers will charge an administration fee to your insurance for giving the shot. For uninsured patients; Vaccination Providers can get this fee reimbursed by the Health Resources and Services Administration's Provider Relief Fund. I have fully disclosed my health insurance coverages, health insurance policies in my vaccine reservation & registration form.
10) I as a patient or guardian grant consent of treatment & vaccination to patient including in my absence and I authorize to release any or all info needed to procure vaccine, comply with CA Departments of Health reporting, process any claims, & payments of benefits directly to Silicon Valley Medical Clinic, Inc. I understand that my immunization & health & demographics data will be shared with immunization registry (CAIR2 & CalVax), Vaccine maker & CDC). After vaccination, patient will be given Covid-19 Vaccination Record Card. I acknowledge that I will need to schedule a second dose of vaccine. I consent to receiving email or text or voice messages with reminders regarding my COVID-19 vaccine appointments. I understand that such messages will not be sent securely.
11) I declare, under penalty of perjury, under the laws of the State of California that the foregoing & data submitted for vaccine reservation & patient registration is true and correct to the best of my knowledge and belief.

Patient or Authorized Signature: Sign & Submit pages 1 & 2. Bring these pages on days of Vaccination.

On Day of 1st Injection:_____ **Date:**_____

On Day of 2nd Injection:_____ **Date:**_____

On Day of Booster Injection: _____ **Date:** _____

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For Clinic Use Only: >Reviewed By:_____ **Uploaded:**_____

Thin Needle & Longer Compression:_____ **15 Min Observation:**_____ **Consult Required:**_____

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