COVID 19 Pre-Screening Questions

Are you feeling sick today?
Yes No Not Sure

Have you ever received a dose of COVID-19 vaccine?
Yes No Not Sure

Have you had a severe allergic reaction (anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?
Yes No Not Sure

Do you have bleeding disorder or are you taking a blood thinner?
Yes No Not Sure

Have you received passive antibody therapy as treatment for COVID-19?
Yes No Not Sure

Do you have one or more chronic diseases?
Yes No Not Sure

Review the below list of conditions known to increase the risk of severe illness to COVID-19:

Asthma Cancer Cerebrovascular Disease Chronic Obstructive Pulmonary Disease Chronic Kidney Disease Cystic Fibrosis Hypertension or High Blood Pressure Type 1 Diabetes Mellitus Type 2 Diabetes Immunocompromised from solid organ transplant Immunocompromised state (weakened immune system)	Liver Disease Neurologic conditions, such as Dementia Overweight (BMI > 25kg/m2, but < 30kg/m2) Pregnancy Pulmonary Fibrosis (having damaged or scarred lung tissues) Sickle Cell Disease Smoker Thalassemia (a type of blood disorder)

How many conditions known to increase risk of severe illness from Covid-19 do you have?
None 1 2 or More

Consent for Vaccination:Signature of Patient _____
Printed Name _____
Date _____ (DD) / _____ (MM) /_____ (YYYY)

OR

Signature of Parent or Legal Guardian or Legal Representative
_____
Printed Name _____
Date _____ (DD) / _____ (MM) /_____ (YYYY)