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Patient Information (Please print clearly)**:**

Poly EmplID: _____ Cal Poly E-mail: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ____ / ____ / ____ Mobile Phone #: ( ) ____ - ____ Gender: _____

Address: _____ Apt./Rm. #: _____

City: _____ State: _____ Zip: _____ County: _____

Pre-Vaccination Checklist for COVID-19 Vaccines:

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(s), it does not necessarily mean you should not get vaccinated. It just means additional questions may be asked.

☐ Yes ☐ No ☐ Unknown	1. Are you feeling sick today?
☐ Yes ☐ No ☐ Unknown	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: _____

☐ Yes ☐ No ☐ Unknown	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 Epi Pen 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 the 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

☐ Yes ☐ No ☐ Unknown	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 Epi Pen 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 ☐ Unknown	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.
☐ Yes ☐ No ☐ Unknown	6. Have you received any vaccine in the last 14 days?
☐ Yes ☐ No ☐ Unknown	7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?

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☐ Yes ☐ No ☐ Unknown	8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?
☐ Yes ☐ No ☐ Unknown	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?
☐ Yes ☐ No ☐ Unknown	10. Do you have a bleeding disorder or are you taking a blood thinner?
☐ Yes ☐ No ☐ Unknown	11. Are you pregnant or breastfeeding?
☐ Yes ☐ No ☐ Unknown	12. Do you have dermal fillers?

Information Statement (Please check off the following statements)**:**

- ☐ I have been given a copy and have read the COVID-19 VACCINE FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA).
- ☐ I understand the Moderna / Pfizer vaccines require two doses. Two doses will need to be administered for the vaccine to be effective.
- ☐ I consent to vaccine-related care.
- ☐ I have been given a chance to ask questions which were answered to my satisfaction.
- ☐ I understand the benefits and risks associated with this vaccine; I am requesting that the vaccine be given to me.
- ☐ I acknowledge that I have been instructed to remain at the vaccination location for a minimum of 15 minutes for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- ☐ I give consent to release my information to the California Department of Public Health (CDPH) and the California Immunization Registry (CAIR).
  (CAIR is a free service of CDPH. The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included.)

Signature of Person to Receive Vaccine: X _____ **Date:** _____

☐ **Data Entered into Electronic Health Record**

FOR VACCINATOR TO COMPLETE (IF ELECTRONIC HEALTH NOT AVAILABLE)

Date Vaccine Administered: _____ **Time:** _____

Vaccine Manufacturer: ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ 1st Dose ☐ 2nd Dose

Vaccine Lot Number: _____ **Expiration Date of Vaccine:** _____

Site of Injection (IM)**:** ☐ Left Deltoid ☐ Right Deltoid

Patient to complete observation: ☐ 15 minutes ☐ 30 minutes

Signature and Title of Vaccine Administrator: X _____

Emergency Use Authorization:

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). THE EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.