# Pre-vaccination Assessment and Consent: COVID-19 Vaccine

**Individuals should be given the EUA Fact Sheet for Recipients and Caregivers before vaccination | *Under the Food and Drug Administration (FDA) Emergency Use Authorization (EUA) individuals 16 years of age and older (Pfizer BioNTech) and 18 years and older (Moderna) may receive this vaccination.**

| | |
|---|---|
| **Last Name, First Name (PRINT)** | **Date: ____/____/_____** |
| **Date of Birth: _____/_____/_____** | **Please state the ethnicity/race you MOST identify with:** |

**Please prepare to provide your ID card to the Clinical Staff**

**Please answer the following questions before the recipient's vaccine appointment. If the recipient answers "yes" to any question, it does not necessarily mean that the recipient should not be vaccinated.**

| | | |
|---|---|---|
| 1. Is the recipient feeling sick today? | **YES** | **NO** |
| 2. Has the recipient ever had an 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 reaction includes a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused the recipient 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** |
| 3. Has the recipient ever had an allergic reaction* to polysorbate? (A severe reaction includes a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused the recipient 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** |
| 4. Has the recipient ever had an allergic reaction* to another vaccine (other than COVID-19 vaccine) or another injectable medication? (This would include a severe reaction includes a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused the recipient 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** |
| 5. Has the recipient ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of the COVID-19 vaccine, polysorbate or any vaccine or injectable mediation? This would include food, pet, venom, environmental or oral medication allergies. | **YES** | **NO** |
| 6. Had the recipient received another vaccine in the **last 14 days?** | **YES** | **NO** |
| 7. Has the recipient ever had a positive test for COVID-19 or has a doctor ever told the recipient that they had COVID-19? | **YES** | **NO** |
| 8. Has the recipient received passive antibody therapy (monoclonal antibodies, convalescent plasma) as treatment for COVID-19? | **YES** | **NO** |
| 9. Does the recipient have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? | **YES** | **NO** |
| 10. Does the recipient have a bleeding disorder or are they taking a blood thinner? | **YES** | **NO** |
| 11. Is the recipient pregnant? ☐**Not Applicable** | **YES** | **NO** |



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MAUI HEALTH

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| | | |
|---|---|---|
| 12. Is the recipient breastfeeding (nursing)?<br>☐**Not Applicable** | **YES** | **NO** |
| 13. Has the recipient ever had an allergic reaction* to previous dose of COVID-19 vaccine? (A severe reaction includes a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused the recipient 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).<br>☐**I have not received previous dose of COVID-19 vaccine** | **YES** | **NO** |
| 14. Has the recipient ever received a dose of COVID-19 vaccine?<br>**If yes: Manufacturer:** **Date:** _____/_____/_____<br>☐Pfizer-BioNTech<br>☐Moderna<br>☐**YES, but I don't know which COVID-19 vaccine I received** | **YES** | **NO** |

**If you have any additional questions, please talk with your physician or healthcare provider before receiving the COVID-19 vaccine.**

**I consent to health evaluations, administration and monitoring necessary for immunization for COVID-19 as ordered or provided by doctors, nurses, assistants, or other staff employed or contracted by Maui Health. I also consent to any necessary treatment, whether diagnostic or therapeutic, should I have an adverse reaction to the vaccine. I acknowledge receipt of the Emergency Use Authorization Fact Sheet and my questions, if any, have been answered.**

☐The recipient has received the EUA Fact sheet(s) for COVID-19 Vaccine(s). The recipient acknowledges that they have received a copy of the Privacy Policy and Terms and Conditions.

**Signature** _____**Time:** _____ (circle one) SELF / PARENT / GUARDIAN

**Thank you for filling this Pre-Questionnaire**
You can return this form and show your ID to the Clinical Staff that will administer your vaccination.

## VACCINE ADMINISTRATION DOCUMENTATION

**Name/Title (PRINT)** _____**Time** _____ AM/PM | **Deltoid Site: Right or Left**

**Product Name/Manufacturer:** ☐**Pfizer BioNTech** ☐**Moderna** **Lot #1**_____ **Exp. Date** _____

| **Identification Match** | **Successful** | **Wasted Dose** |
|---|---|---|
| ☐**Yes** ☐**No** | ☐**Yes** ☐**No** | ☐**Yes** ☐**No** |

## FOR CLINIC USE ONLY

❑ Cleared: assessment done and no valid contraindications ❑ Not cleared: patient referred to provider

**X** _____ Date: ____/____/____
Staff Name: ❑ RN ❑ Practitioner MM DD YY

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** “PEG Polyethylene glycol (PEG) is a common, water-soluble ingredient in a wide variety of commercial products including some vaccines and medications. It is the primary ingredient in many colonoscopy preparations (Golytely) and constipation treatment (Miralax) along with IV medications such as PEGylated medications. It is also in ultrasound gel and injectable steroid injections such as methylprednisolone acetate. Reactions to polyethylene glycol are rare but anaphylaxis has been reported. “

**Definition of Anaphylaxis:**

Anaphylaxis (say "ann-uh-fuh-LAK-suss") is a severe allergic reaction that affects the entire body (systemic). It can occur within a few seconds or minutes after a person is exposed to a substance (allergen or antigen).

Symptoms and signs of a severe allergic reaction may include:

- Itching.
- Raised, red bumps on the skin (hives or wheals).
- Wheezing or difficulty breathing.
- Rapid swelling, either in one area or over the entire body. Swelling is most serious when it involves the lips, tongue, mouth, or throat and interferes with breathing.
- Belly pain or cramps.
- Nausea or vomiting.
- Low blood pressure, shock, and unconsciousness.

The sooner symptoms occur after exposure to the substance, the more severe the anaphylactic reaction is likely to be. An anaphylactic reaction may occur with the first exposure to an allergen, with every exposure, or after several exposures. An anaphylactic reaction can be life-threatening and is a medical emergency. Emergency care is always needed for an anaphylactic reaction.

Current as of June 29, 2020

Author: Healthwise Staff