North Park Pediatrics

COVID-19 Vaccine Screening Questionnaire

Patient's Name:_____ **Date of Birth:**_____

Age:_____**years** **Gender M F** (circle one)

	YES	NO
1. Has the patient ever received a dose of COVID-19 vaccine (Pfizer, Moderna, other)? a. If so, which one? _____ b. If so, what was the date of the first dose? _____ Second dose? _____		
2. Has the patient ever had a severe allergic reaction (anaphylaxis) to anything?		
3. Has the patient ever had an allergic reaction to another vaccine (other than COVID-19 vaccine)?		
4. Has the patient ever had a severe allergic reaction to a component of the COVID-19 vaccine, including polysorbate (which is found in some vaccines, film coated tablets, and IV steroids) or polyethylene glycol (PEG), which is found in some medications such as laxatives and preparations for colonoscopy procedures?		
5. Has the patient ever been prescribed an epipen/Auvi-Q/epinephrine autoinjector?		
6. Has the patient received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?		
7. Does the patient have a weakened immune system caused by something such as HIV infection or cancer or does the patient take immunosuppressive drugs or therapies?		
8. Does the patient have a bleeding disorder or are they taking a blood thinner?		
9. Does the patient have a history of myocarditis or pericarditis? a. If yes, was it after a dose of COVID-19 mRNA?		
10. Has the patient been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?		
11. Does the patient have a history of Guillain-Barre syndrome?		
12. Is the patient in quarantine or isolation for COVID-19?		
13. Is the patient feeling sick today?		

Signature of parent/guardian: _____ Date: _____

Please print name of parent/guardian: _____