

# COVID-19 Screening for Vaccination Administration

***(TO BE PROVIDED TO PATIENT PRIOR TO VACCINATION ADMINISTRATION  
RETAIN WITH VACCINATION RECORDS)***

## **Patient:**

Please complete the form below. This assessment is intended to be used as a screening tool prior to the administration of immunization services. This is not a diagnostic tool for determining COVID-19. All patients with confirmed or suspected cases of COVID-19 should follow CDC and physician guidance and refrain from immunizations until directed by a medical professional.

*To be completed by patient or patient's legal guardian if under 18 years of age:*

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Month          Day          Year

**Please Indicate YES or NO in the appropriate field below.**

**Are you currently experiencing any of the following symptoms:**

|  |  |
|--|--|
| Fever greater than 100.4 °F (38.0 °C) within the past 72 hours                                       | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Shortness of breath  | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Cough  | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Chills   | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Chills with repeated shaking   | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Muscle Pain  | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Headache   | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Sore Throat  | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Loss of taste or smell   | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Nausea/Vomiting or Diarrhea  | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Are you ill or caring for someone who is ill?  | YES <input type="checkbox"/> NO <input type="checkbox"/> |
|  |  |
| Have you been in contact with a person who has tested positive for COVID-19 within the past 2 weeks? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Have you or someone in your place of residence contracted COVID-19?                                  |  |
| If yes, when?  | YES <input type="checkbox"/> NO <input type="checkbox"/> |

*I attest that the information provided above is to my knowledge is accurate and true*

*Patient Signature* \_\_\_\_\_ *Date* \_\_\_\_\_

*(If patient is a minor, legal guardian must attest and sign the above document)*