

COVID-19 Vaccine Screening Form

SCREENING—COVID-19 Vaccine

Version 2.0 – July 19, 2021

Last Name		First Name		Identification number (e.g., health card, passport, birth certificate, driver's license)	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Other: _____				Name of your Primary Care Clinician (Family Physician or Nurse Practitioner)	
Home Phone	Mobile Phone	Email Address			
Street Address			City	Province	Postal Code
Date of Birth (month, day, year) ____ / ____ / ____	Age	Is this your first or second dose of the vaccine? <input type="checkbox"/> First <input type="checkbox"/> Second Name of Vaccine: _____ If second, please indicate the date of the first dose: ____ / ____ / ____ (month, day, year)			

Please answer all questions below:

If the client is receiving the AstraZeneca/COVISHIELD or Janssen COVID-19 Vaccine, the following three questions apply:	
Have you experienced major venous and/or arterial thrombosis with thrombocytopenia following vaccination with any vaccine? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please provide details
Have you experienced a previous cerebral venous sinus thrombosis (CVST) with thrombocytopenia or a heparin-induced thrombocytopenia (HIT)? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please provide details
Have you experienced a previous episode of capillary leak syndrome? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please provide details

<p>Have you been diagnosed with myocarditis or pericarditis following the first dose of an mRNA COVID-19 vaccine?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p>Have you been sick in the past few days? Do you have symptoms of COVID-19 or have a fever today?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p>Have you had a serious allergic reaction within 4 hours to the COVID-19 vaccine before?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p>Do you have allergies to polyethylene glycol, tromethamine (Moderna only) or polysorbate?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p>Have you had a serious allergic reaction to a vaccine or medication given by injection (e.g., IV, IM), needing medical care?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p>Have you received another vaccine (not a COVID-19 vaccine) in the past 14 days?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p>Do you have a weakened immune system or are you taking any medications that can weaken your immune system (e.g., high dose steroids, chemotherapy)?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p>If yes, are you receiving stem cell therapy, CAR-T therapy, chemotherapy, immune checkpoint inhibitors, monoclonal antibodies or other targeted agents?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p>Do you have a bleeding disorder or are taking blood thinners?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>
<p>Have you ever felt faint or fainted after receiving a vaccine or medical procedure?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>If yes, please provide details</p>