COVID-19 VACCINE SCREENING FORM

CHILD'S NAME:________________________________DOB:____________ AGE:______

If your child has already received their 1st dose of a COVID-19 vaccine, please tell us the date it was received.

Dose 1 Vaccination date: ____________

	YES	NO	Don't Know
Is your child sick today or have a fever?			
Has your child had an allergic reaction to polysorbate, polyethylene glycol or a previous dose of COVID-19 vaccine?			
Has your child had a serious allergic reaction (anaphylaxis) to another vaccine or any injectable medication?			
Has your child had a severe allergic reaction (anaphylaxis) to foods, pets, venom, environmental or oral medications?			
Does your child have a bleeding disorder, are on long-term aspirin therapy, or take other blood thinners?			
Has your child ever had Guillain-Barre Syndrome after receiving a vaccine?			
Has your child had convalescent plasma or monoclonal antibodies as part of COVID-19 treatment in the past 3 months?			
Does your child have a history of myocarditis or pericarditis after receiving a dose of an mRNA vaccine?			
Does your child have a history of heparin-induced thrombocytopenia?			
Does your child have a history of Multisystem Inflammatory Syndrome known as MIS-C after a Covid-19 infection?			

PLEASE PRINT PARENT NAME: ______________________________

PARENT SIGNATURE: _______________________________ TODAY'S DATE: _______________