COVID-19 Vaccine Questionnaire & Acknowledgment Form

Please read the COVID-19 Emergency Use Authorization (EUA) Fact Sheet for Pfizer, Moderna or Janssen if you have not done so already.

1. You have a history of a severe allergic reaction (e.g., anaphylaxis) to any vaccine or COVID-19 vaccine products* that required medical attention in the past?
   Please circle: Yes or No

2. Have you experienced a high fever or severe illness in the past 7 days?
   Please circle: Yes or No

   If yes, you are not eligible to receive the COVID-19 vaccine until your fever or illness has resolved for at least 24 hours without the use of a fever-reducing medication.

3. In the past have you experiences a severe allergic reaction (anaphylaxis) to anything besides vaccines, such as a reaction to a medication (oral or injectable), food, bee sting to the point where medical attention was needed?
   Please circle: Yes or No

   If yes, you can get the vaccine. But because of your specific health needs, you will likely need to be monitored for 30 minutes after your vaccine.

4. Check any items that apply to you:
   _____Bleeding disorder and are on blood thinners
   _____Are immunocompromised or on a medication that affects your immune system
   _____Pregnant or plan to become pregnant
   _____Currently breastfeeding

   If yes, you can receive this COVID-19 vaccine. You may wish to discuss any questions you have about your health with your personal physician prior to scheduling your appointment.

5. Do you have a history of Guillain Barre Syndrome?
   Please circle: Yes or No
   If Yes, please acknowledge that you have discussed receiving the vaccine with your neurologist by initialing here _____

6. Have you received any other vaccinations in the past 14 days?
   Please circle: Yes or No

   If yes, then you are not eligible to receive the COVID-19 vaccine until 14 days have passed since your last vaccine.

7. Have you received convalescent plasma or received monoclonal antibody infusions for SARS-CoV-2 (COVID-19) in the last 90 days?
   Please circle: Yes or No

   If yes, you are not eligible to receive the COVID-19 vaccine until 90 days have passed since therapy.

8. Have you received another COVID-19 vaccine. If yes, date _____ & Pfizer or Moderna or Janssen (Circle)

9. Do you work for the school district? Yes or no (circle)

Acknowledgment

You hereby acknowledge and agree to the following statements:

• If I received the first dose of Pfizer COVID-19, I agree to receive the second dose of Pfizer COVID-19 in 21 days. If I received the Moderna COVID-19 vaccine, I agree to receive the second dose of the Moderna vaccine in 28 days from the first dose.

• If I experience any severe allergic reactions (e.g., difficulty breathing, swelling in face or throat, rash all over your body, dizziness or weakness, fast heartbeat that is new), I agree to contact the Employee Health Clinic as an employee. As a patient or community member, I agree to call 911 and report the adverse reaction using www.vaers.hhs.gov or call 1-800-822-7967.

• I acknowledge that I have read the F.D.A.'s COVID-19 Emergency Use Authorization Fact sheet.

• I understand I should continue safety practices such as wearing a face mask, social distancing and frequent hand washing.

• I understand that protection against COVID-19 may not be effective until at least 7 -14 days after the second dose of Pfizer or Moderna or after first dose of Janssen.

• By submitting this Acknowledgment, I am requesting to receive the COVID-19 vaccine.

_____ _____

Printed Legal Name Date of Birth

_____ _____

Signature Date