COVID-19 Screening Questionnaire for Immunizations

Store #: _____ Rx #: _____

Last Name: _____ First Name: _____ Date of Birth: _____

Screening Questions:	**YES**	**NO**
1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID -19?	☐	☐
2. In the past two weeks, have you had contact with someone who tested positive for COVID-19?	☐	☐
3. Do you currently or have you in the past 14 days, experienced the new onset of a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	☐	☐

- If patient answers yes to any of these questions, please inform them that they should not receive the vaccine at this time and instruct them to contact their primary care provider for next steps.
- If the patient's bodily temperature is 100^{o}F or greater, they should not receive the vaccine at this time. Patient should be instructed to contact their primary care provide next steps.

**Attach form to standard consent form and store with immunization records*

Patient Temperature: _____ Date: _____

_____ _____

Administering Immunizer Name & Title

Administering Immunizer Signature