Pre-vaccination Checklist for COVID-19 Vaccines

I AM DEAF OR HARD OF HEARING

I am using this card to communicate.
I may need a certified sign language interpreter or captioning to communicate.

Patient Name _____ DOB _____

Y: Yes | **N:** No | **?:** Unknown

	Y	N	?
Have an appointment?	☐	☐	☐
Do you feel sick today?	☐	☐	☐
Already received a dose of the COVID-19 Vaccine?	☐	☐	☐

Brand _____

	Y	N	?
Do you have severe allergies?	☐	☐	☐

Food ◎ Pets ◎ Medication ◎ Shots ◎

Other _____ Need an EpiPen? ◎

	Y	N	?
Have you received any other vaccines in the last 14 days?	☐	☐	☐
Have you ever tested positive for COVID-19?	☐	☐	☐
Did you receive antibody therapy for COVID-19?	☐	☐	☐
Do you have HIV, Cancer or take immunosuppresant drugs?	☐	☐	☐
Have bleeding disorder or take blood thinners?	☐	☐	☐
Pregnant or breastfeeding?	☐	☐	☐
Do you get dizzy, or lightheaded after a vaccine or needle injection?	☐	☐	☐

Source: Centers for Disease Control and Prevention

de.gov/covidvaccine

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health