Pre-vaccination Checklist for PFIZER COVID-19 Vaccines for children 5-11 years of age :

Patient Name: _____ Patient age: _____ Patient DOB: _____

Is the patient feeling sick today?	YES	NO
Has the patient received a dose of COVID-19 Vaccine	YES, please specify which vaccine and date:	NO

Has the patient ever had an allergic reaction* to the following ingredients: (*this would include a severe allergic reaction (i.e. anaphylaxis) that required treatment with epinephrine or Epipen or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, respiratory distress, including wheezing):

Polyethylene glycol (PEG) which is found in some predications, such as laxatives and preparations of colonoscopy procedures	YES	NO
Nuceloside-modified mRNA encoding the viral spike (s) glycoprotein of SARS-CoV2	YES	NO
1,2-diasteaoryl-sn-glycero-3-phosphocholine	YES	NO
Cholesterol		
(4-hydroxybutyl)azanediyl)bis(hexane 6,1-diyl)bis(2-hexyldecanoate), sodium chloride, monobasic potassium phosphate, potassium chloride, dibasic sodium phosphate dihydrate, sucrose	YES	NO
A previous dose of COVID-19 vaccine	YES	NO

[If the answer is yes, please verbally tell your health care provider. The patient is NOT eligible for COVID-19 vaccination]

Has the patient ever had an allergic reaction to another vaccine (OTHER THAN COVID-19 vaccine) or an injectable medication? (this would include a severe allergic reaction (i.e. anaphylaxis) that required treatment with epinephrine or Epipen or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing).

YES	NO

[If the answer is yes, you must be observed for 30 minutes following vaccination]

Has the patient ever had a severe allergic reaction to something other than a vaccine/injectable therapy such as FOOD, PET, VENOM, ENVIRONMENTAL or ORAL MEDICATION ALLERGIES.

YES	NO

[if the answer is yes, you must be observed for 30 minutes following vaccination]

Circle all that apply to the patient:

Had myocarditis/pericarditis after a first dose of MRNA COVID-19 vaccine	Had multisystem inflammatory syndrome (MIS-C)	Has a weakened immune system (i.e. HIV infection, cancer)	Takes immunosuppressive drugs/therapies
Had myocarditis/pericarditis UNRELATED to COVID-19 vaccination	Has a bleeding disorder or takes a blood thinner	NONE OF THE ABOVE	

Parent name: _____ Parent signature: _____ Form reviewed by: _____ DATE: _____