

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

Have an appointment? **Y N ?**
☐ ☐ ☐

Do you feel sick today? **Y N ?**
☐ ☐ ☐

Already received a dose of the COVID-19 Vaccine? **Y N ?**
☐ ☐ ☐

Brand _____

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

 Food ☐  Pets ☐  Medication ☐  Shots ☐

Other _____ Need an EpiPen? ☐

Have you received any other vaccines in the last 14 days? **Y N ?**
☐ ☐ ☐

Have you ever tested positive for COVID-19? **Y N ?**
☐ ☐ ☐

Did you receive antibody therapy for COVID-19? **Y N ?**
☐ ☐ ☐

Do you have HIV, Cancer or take immunosuppressant drugs? **Y N ?**
☐ ☐ ☐

Have bleeding disorder or take blood thinners? **Y N ?**
☐ ☐ ☐

Pregnant or breastfeeding? **Y N ?**
☐ ☐ ☐

Do you get dizzy, or lightheaded after a vaccine or needle injection? **Y N ?**
☐ ☐ ☐

Source: Centers for Disease Control and Prevention

de.gov/covidvaccine



DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health