*****Please fill in name and answer questions 1 – 10*****

Name (First & Last)	

PFIZER-BIONTECH COVID-19 VACCINE SCREENING QUESTIONNAIRE

COVID-19 PRE-VACCINATION ASSESSMENT — PLEASE COMPLETE	**YES**	**NO**
IF "YES" TO ANY OF THE FOLLOWING QUESTIONS 1 – 5, DO NOT VACCINATE		
1. Are you younger than 12 years?		
2. Have you received COVID-19 monoclonal antibody or convalescent plasma treatments within the last 90 days?		
3. Do you have a fever of 100.5 degrees Fahrenheit or are you moderately or very ill today?		
4. Are you currently quarantining for COVID-19 or tested positive for Covid-19 within the last two weeks?		
5. Have you received any other vaccines within the past 14 days?		
IF "YES" TO QUESTION 6, DO NOT VACCINATE WITH BNT162b2 COVID-19 VACCINE (Pfizer-BioNTech)		
6. Have you had a severe allergic reaction of anaphylaxis to any component of the BNT162b2 COVID-19 vaccine (Pfizer-BioNTech)? mRNA, lipids ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)- 2000]-N,N-ditetradecylacetamide, 1,2-Distearoyl-sn-glycero-3-phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose		
IF "YES" TO QUESTION 9: (WILL REQUIRE 30 MINUTE OBSERVATION)		
9. Do you have a history of severe allergic reaction (e.g., anaphylaxis; symptoms may involve tongue or throat swelling and/or shortness of breath)?		
IF "YES" TO QUESTION 10: (WILL REQUIRE 30 MINUTE OBSERVATION)		
10. Do you have a history of severe allergic reaction (e.g., anaphylaxis) to a vaccine or injectable medication, or unexplained severe allergic reaction (e.g., anaphylaxis)?		

VACCINATOR PLEASE COMPLETE SECTION BELOW

LIM#	**Vaccine Descriptor**	**Type**	**AGE**	**Dose/Route/Site**
1111	BNT162b2 COVID-19 Vaccine	MDV	16+ yrs	0.3 mL IM **L / R** Deltoid

Administered By (initials):

Date Administered: