Pre-vaccination Checklist for COVID-19 Vaccines

Patient Name: ____________________________ DOB: ________

- **Pregnant or breastfeeding?**
  - NO
  - DON'T KNOW
  - YES

- **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.

- **Have an appointment?**
  - YES
  - NO
  - DON'T KNOW

- **Sick today?**
  - YES
  - NO
  - DON'T KNOW

- **I am getting:**
  - Pfizer
  - Moderna
  - Johnson & Johnson
  - 1st Dose
  - 1st Booster
  - 2nd Dose
  - 2nd Booster
  - Date of Last Dose

- **Severe allergy to:**
  - Food
  - Pets
  - Meds
  - Shots
  - Other __________
  - Need EpiPen®?

- **Receive any other vaccines in last 14 days?**
  - YES
  - NO
  - DON'T KNOW

- **COVID-19 positive before?**
  - YES
  - NO
  - DON'T KNOW

- **Receive antibody therapy for COVID-19?**
  - YES
  - NO
  - DON'T KNOW

- **Have HIV, cancer or take immunosuppressant drugs?**
  - YES
  - NO
  - DON'T KNOW

- **Have bleeding disorder or take blood thinners?**
  - YES
  - NO
  - DON'T KNOW

- **Pregnant or breastfeeding?**
  - YES
  - NO
  - DON'T KNOW

Source: Centers for Disease Control and Prevention

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