Registration and Pre-vaccination Questionnaire:

Strafford County Students 5/15/21

Please complete all sections before going to the clinic. Please print clearly.

First name (given name)				
Last name (family name)				
Gender (mark with an X)	Male	Female	Unknown/ Unreported	Other
Date of Birth	_____/_____/_____			
Are you Hispanic / Latino?	Yes	No	Don't Know/ Unreported	
Race (check all that apply)	American Indian or Alaska Native	Asian	Black or African American	
	Native Hawaiian or Pacific Islander	White	Unknown/ Unreported	
Home address: Street				
Home address: City				
Home address: State				
Home address: Zip Code				
Email address:				
Phone number:				

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Age 18 or older _____
Verbal parental consent _____
Signed consent form (if parent/guardian not present) _____

GREATER SEACOAST COMMUNITY HEALTH

STRAFFORD COUNTY PUBLIC HEALTH NETWORK

Screening Questions	Yes	No
Are you feeling sick today?		
Have you ever received a dose of a Covid-19 Vaccine? If yes, which one? (circle one) Pfizer Moderna Johnson&Johnson		
Have you ever had an allergic reaction to a component of the COVID-19 vaccine, including **polyethylene glycol (PEG**), which is found in some medications, such as laxatives and preparations for colonoscopy procedures		
Have you ever had an allergic reaction to **polysorbate**?		
Have you ever had an allergic reaction to a **previous dose of a Covid-19 vaccine**?		
Have you ever had an allergic reaction to **another vaccine** (other than COVID-19 vaccine) or an injectable medication?		
Have you ever had a severe allergic reaction (e.g., **anaphylaxis**) to **something other than a component of COVID-19 vaccine**, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.		
Have you received any vaccine in the last 14 days?		
Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?		
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
Do you have a bleeding disorder or are you taking a blood thinner?		
Are you pregnant or breastfeeding?		

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Vaccinator: Write lot number here when vaccine administered_____

IF VACCINE NOT ADMINISTERED MARK HERE _____