Cayuga County Health Department
School Based Clinic Screening Form (5 – 11)
Pfizer COVID-19 Vaccination

Patient Name: _____ Patient DOB: _____

School District: _____

Please answer the following screening questions completely on behalf of your child:

1. Are you between the ages of 5 and 11 years old? **____ Yes ____ No**

2. Are you 12 years old or older? **____ Yes ____ No**

3. Are you feeling sick today? **____ Yes ____ No**

4. In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure? **Please note that if you child has recently tested positive for COVID-19 they must be at minimum 14 days past their 10th day of isolation and symptom free.
_____ Yes ____ No

5. Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? If yes, when was your last dose? ** Please note if you have received any antibody or convalescent plasma treatment you must wait 90 days (3 months) from your last treatment before receiving the vaccine. **____ Yes _____ Date of last Dose ____ No**

6. Have you ever had an immediate allergic reaction, such as hives, face swelling, difficulty, breathing or anaphylaxis, to any vaccine, injection or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything? **_____ Yes ____ No**
   If yes please answer the following additional questions regarding the reaction:
   What was the reaction? _____
   What was the medication? _____
   How was the medication administered? (Orally, intravenous (IV) or intramuscular (IM)) _____

7. Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other conditions that weaken the immune system? If yes, have you spoken with your healthcare provider regarding vaccination? **____ Yes ____ No**

8. Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments? **____ Yes ____ No**

9. Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?
____ Yes ____ No

10. Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)? **____ Yes ____ No**

11. Have you received a previous dose of the Pfizer, Moderna or Janssen COVID-19 vaccine? **____ Yes ____ No**

12. Have you received a previous dose of a COVID-19 vaccine authorized by the WHO but not by the FDA (AstraZeneca – VAXZEVRIA, Sinovac – CORONAVAC, Serum Institute of India – COVISHIELD, Sinopharm/BIBP)? **____ Yes ____ No**

_____	_____	_____	_____
Parent/Guardian (Signature)	Date	Print Name	Relationship to Child

Date: _____
Vaccinator: _____
Lot No. _____
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