Cayuga County Health Department
School Based Clinic Screening Form
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 feeling sick today? **____ Yes ____ No**

2. In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate at home due to COVID-19 infection? In the last 10 days, have been told by a healthcare provider or health department to quarantine at home due to COVID-19 exposure or travel? **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

3. 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**

4. Have you ever had an immediate allergic reaction, such as hives, face swelling, difficulty, breathing or anaphylaxis, to any vaccine or shot or to any component of the COVID-19 vaccine, such as polyethylene glycol (PEG) or polysorbate? **_____ 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))
_____

5. Have you had any vaccines in the last 14 days (2 weeks) including a flu shot? If yes, how long ago was your most recent vaccine? *** Please note this does not include allergy shots or insulin injections. **_____ Yes _____ Date _____ No**

6. Are you pregnant or considering becoming pregnant? **____ Yes ____ No**

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 or are you taking any blood thinners? **____ Yes ____ No**

10. Have you received a previous dose of COVID-19 vaccine? **____ Yes ____ No**