COVID-19 疫苗的接种前检查表

对于疫苗接种者：

以下问题将帮助我们确定是否有任何使得您今天不应该接种 COVID-19 疫苗的原因。**如果您对任何问题的回答为“是”，也不一定意味着您不应接种疫苗。**只是表示可能会询问其他问题。如果某个问题不清楚，请要求您的医疗保健提供者进行解释。

姓名 _____

年龄 _____

	是	否	不知道
1. 您今天感觉不舒服吗？	☐	☐	☐
2. 您是否已经接受过一剂 COVID-19 疫苗？	☐	☐	☐
• 如果是，您接种了哪种疫苗产品？ ☐ Pfizer ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ 其他产品 _____			
• 您是否带了您的疫苗接种记录卡或其他文件？ *（是/否）*	☐	☐	
3. 您是否对以下物质发生过过敏反应： *(这可能包括需要肾上腺素或 EpiPen® 治疗或导致您去医院的重度过敏反应[例如，过敏症]。还包括可导致荨麻疹、肿胀或呼吸窘迫的过敏反应，包括喘息。)*			
• COVID-19 疫苗的组分，包括以下任何一种：			
○ 聚乙二醇 *(PEG)*，可见于某些药物中，例如泻药和用于结肠镜检查的制剂	☐	☐	☐
○ 聚山梨酯，可见于一些疫苗、薄膜衣片和静脉注射类固醇中	☐	☐	☐
• 既往接种过一剂 COVID-19 疫苗	☐	☐	☐
4. 您是否对另一种疫苗 *（不是 COVID-19 疫苗）* 或注射药物有过敏反应？ *(这可能包括需要肾上腺素或 EpiPen® 治疗或导致您去医院的重度过敏反应[例如，过敏症]。还包括可导致荨麻疹、肿胀或呼吸窘迫的过敏反应，包括喘息。)*	☐	☐	☐
5. 勾选所有适用于您的选项：			

- ☐ 是年龄在 18 至 49 岁之间的女性
- ☐ 是年龄在 12 至 29 岁之间的男性
- ☐ 有心肌炎或心包炎病史
- ☐ 对疫苗或注射疗法以外的物质有严重的过敏反应，如食物、宠物、毒液、环境或口服药物过敏
- ☐ 患过 COVID-19 并接受了单克隆抗体或恢复期血清的治疗
- ☐ 感染 COVID-19 后被诊断为多系统炎症综合症（MIS-C 或 MIS-A）
- ☐ 免疫系统功能减弱（即 HIV 感染、癌症）或正在使用免疫抑制药物或治疗
- ☐ 患有出血性疾病
- ☐ 服用血液稀释剂
- ☐ 有肝素诱导的血小板减少症 (HIT) 病史
- ☐ 目前正处于怀孕或哺乳期
- ☐ 曾接受皮肤填充剂
- ☐ 吉兰-巴雷综合征 (GBS) 病史

表格审查人 _____ **日期** _____

在免疫行动联盟 (IAC) 筛选检查表的基础上进行改编，对此表示感谢

Seattle Cancer Care Alliance
1354 Aloha St. Seattle, WA 98109

Pfizer-BioNTech COVID-19 Vaccine Patient Acknowledgment

Patient Name (Last, First): _____ DOB: ____/____/_____

Phone: _____ Mobile Phone: _____Email: _____

Address: _____ City, State, Zip Code: _____

Information collected in this section helps ensure we deliver equitable and patient-centered care:

Sex listed at birth (check one):

Male: ☐	Female: ☐

Gender identity (check one):

Male: ☐	Female: ☐	Non-Binary ☐	Unspecified/Indeterminant: ☐

Ethnicity (Check one):

Hispanic or Latino (Including Spanish, Mexican, Puerto Rican, Cuban, etc. ☐	Not-Hispanic A person not of Spanish culture or origin ☐

Race: (Check all that apply):

Black or African American ☐ White ☐	Asian ☐ American Indian or Alaska Native ☐	Hawaiian or Pacific Islander ☐ Other ☐

Acknowledgements:

- *I made the choice to get the COVID-19 vaccine on my own and freely. I know I have the option to refuse the vaccine. I ask that the vaccine be given to me, or to the person named above for whom I can make this request. I was given the (Fact Sheet for Vaccine Recipients and Caregivers)* for this vaccine. The fact sheet *has information about side effects and adverse reactions. I read or had read to me the information provided about the COVID-19 vaccine.*
- *I know the Food and Drug Administration (FDA) has authorized the emergency use of this vaccine. I know it is not a fully licensed FDA vaccine. I had the chance to ask questions that were answered to my satisfaction. I now know about the vaccine, alternatives, benefits, and risks, to the extent they are known and unknown at this time.*
- *I know that I must stay in the vaccine area or an area told to me by my health care provider after I receive my immunization so I am near my health care provider if I have any adverse reactions.. If I have a history of severe allergic reaction, (e.g. anaphylaxis), I must stay for 30 minutes. If I do not have a history of severe allergic reaction, I must stay for 15 minutes*
- *I know that if I have a severe allergic reaction, including difficulty breathing, swelling of my face and/or throat, a fast heartbeat, a bad rash all over my body or dizziness and weakness I should call 9-1-1 or go to the nearest hospital. I know I can call my health care provider if I have any side effects that bother me or do not go away.*
- *I was asked to join the V-SAFE program. The program does health checks on the people who get the COVID-19 vaccine. I know I should report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 or https://vaers.hhs.gov/reportevent.html.*
- *I know I must get two doses of the COVID-19 vaccine and receive the same vaccine each time. I know that with all vaccines there is no promise I will become immune (not get the virus) or that I will not have side effects. I know I may choose to not get the second dose of the vaccine. But if I do not get the second dose, the chance that I will become immune may go down.*

Disclosure of Records: *I understand the organization providing my vaccine may be required to or may voluntarily disclose my vaccine-related health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also understand the organization providing my vaccine will use and disclose my health information as described in its Notice of Privacy Practices which I may receive upon request or find on its website.*

Patient (or Parent/Guardian/Authorized Representative) Signature: _____ Date: _____

Name of Parent, Guardian or Authorized Representative: _____ Date: _____

If you are signing on behalf of the patient, you are stating that you are authorized to make the required decisions on behalf of the patient.