COVID-19 - Pre-Immunization Screening Checklist

Patient name: ____

Date of birth: _______________________

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any questions, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Today or in the past 2-14 days, have you experienced any of the following:

- Fever or chills — Yes No
- Cough — Yes No
- Shortness of breath or difficulty breathing — Yes No
- Fatigue — Yes No
- Muscle or body aches — Yes No
- Headache — Yes No
- New loss of taste or smell — Yes No
- Sore throat — Yes No
- Congestion or runny nose — Yes No
- Nausea or vomiting — Yes No
- Diarrhea — Yes No

Form completed by (Immunizer):_____________________________________

Patient signature: ____

Riesbeck's Pharmacy Location (circle)

55 South 23rd Street Cambridge, OH 43725	104 Plaza Drive St. Clairsville, OH 43950	4595 Central Avenue Shadyside, OH 43947	2200 June Parkway S. Zanesville, OH 43701	56130 National Rd. Bridgeport, OH 43912

NOTE: Attach this additional screening checklist to patient's Administration Record.

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