

For vaccine recipients:

The following questions will help us determine if there is any reason you should post-pone, or refrain from getting COVID-19 vaccine. If you answer "yes" to any of these questions, please contact your provider at DMC Primary Care at 603-537-1300 to verify if it is still safe to receive your COVID-19 vaccine.

Pre-vaccination Checklist & Consent for COVID-19 Vaccines

			YES	NO
If yes, what product did you receive? Pfizer Moderna Johnson & Johnson Another Product:	1.	Are you feeling sick today?		
A lave you ever had an allergic reaction to: (including anaphylaxis requiring treatment with epi-pen and hospitalization) A component of the COVID-19 Vaccine: O Polyetherlene Glycol O Plysorbate O A previous dose of COVID-19 Vaccine O A vaccine or injectable therapy that contains multiple Components, one of which is a COVID-19 vaccine component but is not known which component elicited the reaction 4. Have you ever had an allergic reaction to another vaccine other than COVID-19 Vaccine? (including anaphylaxis requiring treatment with epi-pen and hospitalization) 5. Have you ever had a severe allergic reaction to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental or oral medication allergies. 6. Have you received any vaccine in the last 14 days? 7. Have you ever had a positive test for COVID-19? Or has a doctor ever told you that you had COVID-19? 8. Have you received passive antibody therapy (monoclonal antibodies or convalescent plasma) as treatment for COVID-19? 9. Do you have a meakened immune system? (caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies) 10. Do you have a biedening disorder or are you taking a blood thinner? 11. Do you have a biedening disorder or are you taking a blood thinner? 12. Are you pregnant or breastfeeding? In Province of the provi	2.	Have you ever received a dose of COVID-19 vaccine?		
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ffices, local health departments, schools, hospitals, and other health care facilities that administer immunizations and rovide medical care to New Hampshire residents.* agree to have my COVID-19 vaccine information shared via the NHIIS vaccine registry. Yes No fully understand the benefits and risks of the vaccination as described. I request that the vaccine be given to me or the erson named below for whom I am authorized to sign. atient/Vaccine Recipient Name: Date of Birth:	New Ha	mpshire participates in a vaccine registry. New Hampshire Immunization Informa	tion System (N	HIIS) is a secure
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		e recipient under 18 – Parent/Guardian Signature:		