Ministry of Health

Ontario

COVID-19 Vaccine Screening Form

SCREENING–COVID-19 Vaccine

Version 3.0 – August 17, 2021

<table>
<tr><td colspan="2">Last Name</td><td colspan="2">First Name</td><td colspan="2">Identification number (e.g., health card, passport, birth certificate, driver's license)</td></tr>
<tr><td colspan="4">Gender: ☐ Female ☐ Male ☐ Prefer not to answer
☐ Other: _____</td><td colspan="2" rowspan="2">Name of your Primary Care Clinician
(Family Physician or Nurse Practitioner)</td></tr>
<tr><td>Home Phone</td><td>Mobile Phone</td><td colspan="2">Email Address</td></tr>
<tr><td colspan="2">Street Address</td><td>City</td><td>Province</td><td colspan="2">Postal Code</td></tr>
<tr><td>Date of Birth
(month, day, year)

_____ / _____ / _____</td><td>Age</td><td colspan="4">Have you previously received one or more doses of a COVID-19 vaccine? If yes, please complete the information below for all doses of vaccine received.
First Dose date: --------/----------/-------- (month, day, year)
First dose name: _____

Second Dose date: --------/----------/-------- (month, day, year)
Second dose name: _____</td></tr>
</table>

Please answer all questions below:

<table>
<tr><td colspan="2">If the client is receiving the AstraZeneca/COVISHIELD or Janssen COVID-19 Vaccine, the following three questions apply:</td></tr>
<tr><td>Have you experienced major venous and/or arterial thrombosis with thrombocytopenia following vaccination with any vaccine?
☐ No ☐ Yes</td><td>If yes, please provide details</td></tr>
<tr><td>Have you experienced a previous cerebral venous sinus thrombosis (CVST) with thrombocytopenia or a heparin-induced thrombocytopenia (HIT)?
☐ No ☐ Yes</td><td>If yes, please provide details</td></tr>
</table>

Have you experienced a previous episode of capillary leak syndrome? ☐ No ☐ Yes	If yes, please provide details
Have you been diagnosed with myocarditis or pericarditis following the first dose of an mRNA COVID-19 vaccine? ☐ No ☐ Yes	If yes, please provide details
Have you been sick in the past few days? Do you have symptoms of COVID-19 or have a fever today? ☐ No ☐ Yes	If yes, please provide details
Have you had a serious allergic reaction within 4 hours to the COVID-19 vaccine before? ☐ No ☐ Yes	If yes, please provide details
Do you have allergies to polyethylene glycol, tromethamine (Moderna only) or polysorbate? ☐ No ☐ Yes	If yes, please provide details
Have you had a serious allergic reaction to a vaccine or medication given by injection (e.g., IV, IM), needing medical care? ☐ No ☐ Yes	If yes, please provide details
Have you received another vaccine (not a COVID-19 vaccine) in the past 14 days? ☐ No ☐ Yes	If yes, please provide details
Do you have a weakened immune system or are you taking any medications that can weaken your immune system (e.g., high dose steroids, chemotherapy)? ☐ No ☐ Yes	If yes, please provide details
If yes, are you receiving stem cell therapy, CAR-T therapy, chemotherapy, immune checkpoint inhibitors, monoclonal antibodies or other targeted agents? ☐ No ☐ Yes	If yes, please provide details
Do you have a bleeding disorder or are taking blood thinners? ☐ No ☐ Yes	If yes, please provide details
Have you ever felt faint or fainted after receiving a vaccine or medical procedure? ☐ No ☐ Yes	If yes, please provide details