Covid-19 Vaccine Downtime Work Around

Patient name _____

Are you feeling ill? ☐ YES ☐ NO

Have you had a COVID-19 test or been told to isolate or quarantine in the last 10 days?
☐ YES ☐ NO

Have you been diagnosed with COVID-19? ☐ YES ☐ NO

Have you been treated with antibody therapy for COVID-19 in the last 3 months?
☐ YES ☐ NO

Have you had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot? ☐ YES ☐ NO

Have you had any vaccines in the past 14 days, including flu shot? ☐ YES ☐ NO

Are you pregnant or considering becoming pregnant? ☐ YES ☐ NO

Do you have an immunocompromising condition? ☐ YES ☐ NO

Do you take medications that affect your immune system including steroids, chemotherapy, or radiation therapy? ☐ YES ☐ NO

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