Ministry of Health

Ontario

COVID-19 Vaccine Screening Form

SCREENING–COVID-19 Vaccine

Version 1.0 – May 21, 2021

Last Name	First Name	Identification number (e.g., health card, passport, birth certificate, driver's license)
Gender: ☐ Female ☐ Male ☐ Prefer not to answer ☐ Other: _____		Name of your Primary Care Clinician (Family Physician or Nurse Practitioner)
Home Phone	Mobile Phone	Email Address
Street Address	City	Province / Postal Code
Date of Birth (month, day, year) _____ / _____ / _____	Age	Is this your **first or second dose** of the vaccine? ☐ First ☐ Second **Name of Vaccine**: _____ If second, please indicate the date of the first dose: _____ / ____ / ____ (month, day, year)

Please answer all questions below:

If the client is receiving the AstraZeneca/COVISHIELD or Janssen COVID-19 Vaccine: **Have you experienced major venous and/or arterial thrombosis with thrombocytopenia following vaccination with any vaccine?** ☐ No ☐ Yes	If yes, please provide details
Have you experienced a pervious cerebral venous sinus thrombosis (CVST) with thrombocytopenia or a heparin-induced thrombocytopenia (HIT)? ☐ 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