

# Pre-vaccination Checklist for COVID-19 Vaccines



## I AM DEAF OR HARD OF HEARING

I am using this card to communicate.  
I may need a certified sign language interpreter or captioning to communicate.



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

YES     NO     DON'T KNOW

(circle one)



Have an appointment?



Sick today?



I am getting:

- 
- 
- 

- 1<sup>st</sup> Dose     1<sup>st</sup> Booster
- 2<sup>nd</sup> Dose     2<sup>nd</sup> Booster

Date of Last Dose

\_\_\_\_\_

Severe allergy to:



Food



Pets



Meds



Shots

Other \_\_\_\_\_

Need EpiPen®?



Receive any other vaccines in last 14 days?



COVID-19 positive before?



Receive antibody therapy for COVID-19?



Have HIV, cancer or take immunosuppressant drugs?



Have bleeding disorder or take blood thinners?



Pregnant or breastfeeding?



Source: Centers for Disease Control and Prevention

New Jersey Department of Human Services  
Division of the Deaf and Hard of Hearing  
Phone: 1-800-792-8339  
Email: DDHH.communications2@dhs.nj.gov

