

## Pre-screening COVID-19 Vaccination Dose 1

<b>Date:</b>	
<b>Name of resident to be vaccinated:</b>	
<b>Date of birth:</b>	
<b>Temperature:</b>	
<b>Pulse:</b>	
<b>SaO2:</b>	
<b>Please indicate if there is an informed consent for the person to be vaccinated:</b>	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

The following screening questions are to be completed for each resident who is to be vaccinated on the day of vaccination. A tick is to be placed in each box and the completed screening form is to be shown to the immunisation provider immediately prior to vaccination.

- is unwell today
  
- has a disease that lowers immunity (e.g., leukaemia, cancer, HIV) or is having treatment that lowers immunity (e.g., oral steroid medicines such as cortisone and prednisone, DMARDs [disease-modifying anti-rheumatic drugs], radiotherapy, chemotherapy)
  
- has had a severe reaction following any vaccine
  
- has **any** severe allergies (to anything)
  
- has had any vaccine in the past month
  
- has a history of Guillain–Barré syndrome
  
- has a severe or chronic illness please list  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
- has a bleeding disorder or is on anti-coagulation therapy
  
- is awaiting results of COVID 19 test
  
- has a positive COVID 19 test result

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Pre-screening COVID-19 Vaccination Dose 2

<b>Date:</b>	
<b>Name of resident to be vaccinated:</b>	
<b>Date of birth:</b>	
<b>Temperature:</b>	
<b>Pulse:</b>	
<b>SaO2:</b>	
<b>Please indicate if there is an informed consent for the person to be vaccinated:</b>	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

The following screening questions are to be completed for each resident who is to be vaccinated on the day of vaccination. A tick is to be placed in each box and the completed screening form is to be shown to the immunisation provider immediately prior to vaccination.

- is unwell today
  
- has a disease that lowers immunity (e.g., leukaemia, cancer, HIV) or is having treatment that lowers immunity (e.g., oral steroid medicines such as cortisone and prednisone, DMARDs [disease-modifying anti-rheumatic drugs], radiotherapy, chemotherapy)
  
- has had a severe reaction following any vaccine
  
- has **any** severe allergies (to anything)
  
- has had any vaccine in the past month
  
- has a history of Guillain–Barré syndrome
  
- has a severe or chronic illness please list  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
- has a bleeding disorder or is on anti-coagulation therapy
  
- is awaiting results of COVID 19 test
  
- has a positive COVID 19 test result

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### Post COVID-19 Vaccination Screening Dose 1

<b>Date of Vaccination:</b>							
<b>Time:</b>							
<b>Name of Resident:</b>							
Date	Time	Pain at Site	Temp.	SaO2	Headache	Chills	Initials

### Post COVID-19 Vaccination Screening Dose 2

<b>Date of Vaccination:</b>							
<b>Time:</b>							
<b>Name of Resident:</b>							
Date	Time	Pain at Site	Temp.	SaO2	Headache	Chills	Initials

## Pre-screening COVID-19 Vaccination - Booster

<b>Date:</b>	
<b>Name of resident to be vaccinated:</b>	
<b>Date of birth:</b>	
<b>Temperature:</b>	
<b>Pulse:</b>	
<b>SaO2:</b>	
<b>Please indicate if there is an informed consent for the person to be vaccinated:</b>	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

The following screening questions are to be completed for each resident who is to be vaccinated on the day of vaccination. A tick is to be placed in each box and the completed screening form is to be shown to the immunisation provider immediately prior to vaccination.

- is unwell today
  
- has a disease that lowers immunity (e.g., leukaemia, cancer, HIV) or is having treatment that lowers immunity (e.g., oral steroid medicines such as cortisone and prednisone, DMARDs [disease-modifying anti-rheumatic drugs], radiotherapy, chemotherapy)
  
- has had a severe reaction following any vaccine
  
- has **any** severe allergies (to anything)
  
- has had any vaccine in the past month
  
- has a history of Guillain-Barré syndrome
  
- has a severe or chronic illness please list  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
- has a bleeding disorder or is on anti-coagulation therapy
  
- is awaiting results of COVID 19 test
  
- has a positive COVID 19 test result

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

## Post COVID-19 Vaccination Screening – Booster

<b>Date of Vaccination:</b>							
<b>Time:</b>							
<b>Name of Resident:</b>							
Date	Time	Pain at Site	Temp.	SaO2	Headache	Chills	Initials