the Chickasaw Nation
Department of Health
Public Health Nursing
1921 Stonecipher Boulevard / Ada, OK 74820 / (580) 436-3980

Bill Anoatubby
Governor

COVID-19 Bivalent Booster Checklist and Registration

Name: _____
First Middle Last Suffix

Date of birth: _____ Mother's maiden name: _____

Phone no.: (____) _____ MR no.: _____

Emergency contact name: _____ Emergency contact phone no.: (____) _____

For Vaccine Recipients – Children and Adults:

The following questions will help us determine if there is any reason the COVID-19 Bivalent Booster cannot be given today. If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given. It means additional questions may be asked. If a question is not clear, please ask the healthcare provider to explain.

1. How old is the person to be vaccinated: _____years
2. Is the person to be vaccinated sick today? ☐ Yes ☐ No
3. Has the person to be vaccinated ever received the **INITIAL** COVID-19 vaccine series? ☐ Yes ☐ No
   If yes, select the product received:
   ☐ Pfizer-BioNTech ☐ Janssen (Johnson and Johnson) ☐ Another product
   ☐ Moderna ☐ Novovax
4. How many doses of the COVID-19 vaccine were administered? _____
5. When was the date of your last vaccination/booster? _____
6. Did you bring the vaccination record card or other documents? ☐ Yes ☐ No
7. Is the person to be vaccinated have a health condition or undergoing treatment that makes them moderately or severely immunocompromised? *(Treatment for cancer, HIV, organ transplant, immunosuppressive therapy, or high-dose corticosteroids, CAR-T cell therapy, hematopoietic cell transplant, or moderate or severe primary immunodeficiency.)*
   ☐ Yes ☐ No ☐ Do not know
8. Is the person to be vaccinated receiving the COVID-19 vaccine **before or during** hematopoietic cell transplant or CAR-T cell therapies? ☐ Yes ☐ No ☐ Do not know
   If yes, STOP will need to complete the primary series again before the booster.
9. Has the person to be vaccinated ever had an anaphylactic allergic reaction to:
   (Required treatment with epinephrine or EpiPen® or that caused you to go to the hospital; also hives, swelling, difficulty breathing, or wheezing)
   a. A component of a COVID-19 vaccine ☐ Yes ☐ No ☐ Do not know
   b. A previous dose of a COVID-19 vaccine ☐ Yes ☐ No ☐ Do not know
   c. Another vaccine or injectable medication ☐ Yes ☐ No ☐ Do not know
10. Check all that apply:
    ☐ History of myocarditis or pericarditis
    ☐ History of thrombosis with thrombocytopenia syndrome (TTS)
    ☐ Guillain-Barre Syndrome (GBS)
    ☐ Multisystem inflammatory syndrome (MIS-C or MIS-A)
    ☐ Pregnant, breastfeeding, or attempting to become pregnant
    ☐ Heparin induced thrombocytopenia (HIT)
    ☐ COVID-19 positive in the last three months

_____ _____
Patient/legal guardian signature Date

_____ _____ _____
Vaccine given by signature Date Time

Injection site: ☐ RD ☐ LD ☐ RVL ☐ LVL

Pfizer-BioNTech COVID-19 Bivalent Lot no./exp: _____

Source: Immunization Action Coalition screening checklist 9/27/2022