Hamilton
Public Health Services

Vaccine Program
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COVID-19 Vaccine Screening Question Form

Please answer all questions below and return to your school with the completed consent form:

Do you have symptoms of COVID-19 or feel unwell today? ☐ Yes ☐ No	If yes, please explain
Have you had any severe allergic reactions to a previous COVID mRNA vaccine or any other vaccine? ☐ Yes ☐ No	If yes, please explain
Are you allergic to any of the components of the COVID-19 vaccine (including polyethylene glycol [PEG] and polysorbate)? ☐ Yes ☐ No	If yes, please explain
Do you have any severe allergies that are not related to vaccinations? (e.g. food, pet, environmental, latex etc.) ☐ Yes ☐ No	If yes, please explain
Have you received another vaccination (not COVID-19) in the last 14 days? ☐ Yes ☐ No	If yes, please explain
Do you have any problems with your immune system or are you taking any medications that can affect your immune system? ☐ Yes ☐ No	If yes, please explain
Do you have an autoimmune disease? ☐ Yes ☐ No	If yes, please explain
Do you have a bleeding disorder or are you taking medications that could affect blood clotting (e.g. blood thinners)? ☐ Yes ☐ No	If yes, please explain
Have you every felt faint or fainted after a past vaccination or medical procedure? ☐ Yes ☐ No	If yes, please explain