COVID 19 Vaccine Screening Questionnaire

If you have had COVID 19 in the last 90 days you are ineligible for the vaccine at this time

Name:_____ Birthdate_____

Phone number:_____Email_____

(Circle Y or N)

Y/N Do you or anyone living in the home have any of the following:
cough, fever, loss of smell or taste, use fever medicine, body aches
shortness of breath, vomiting, diarrhea, abdominal pain, rash?

Y/N Have you or anyone living in the home been diagnosed with COVID in the last 3 months?

Y/N Have you or anyone living in the home been tested for COVID in the last 14 days
or are awaiting results for a COVID test?

Y/N Are you or anyone living in the home on
quarantine due to close contact with someone with COVID-19?

Patient Signature: _____

Date: _____

***If Yes to any of the above, you may not have the vaccine at this time.**
Additional questions, please call one of the phone numbers listed below.

Vicky Kistler	(610) 437-7760	ext.	2824
Belle Marks	(610) 437-7760	ext.	2809
Garry Ritter	(610) 437-7760	ext.	2833
Terry Fasano	(610) 437-7760	ext.	2811

Please bring this completed form with you to your appointment