1. Have you had an immediate allergic reaction of any severity to polysorbate?  
   - Yes  - No

2. Have you had an immediate allergic reaction to any other vaccine or injectable therapy (i.e., intramuscular, intravenous, or subcutaneous vaccines or therapies [excluding subcutaneous immunotherapy for allergies, i.e., “allergy shots”] not related to a component of mRNA COVID-19 vaccines or polysorbate?  
   - Yes  - No

3. Have you had any other vaccine in the last 14 days?  
   - Yes  - No

4. Have you had a severe allergic reaction (within 4 hours of receiving the medication, developed difficulty breathing, hives, swelling around the mouth, throat or eyes) to a previous dose of the COVID-19 vaccine?  
   - Yes  - No

5. Have you required the use of an epipen?  
   - Yes  - No
   - Have you required the use of an epipen due to a reaction to a COVID-19 vaccine?  
     - Yes  - No
   - Have you required the use of an epipen for any vaccine reaction?  
     - Yes  - No
   - Have you required the use of an epipen due to a reaction to oral medication, food, pets, or other causes?  
     - Yes  - No

6. Are you 17 years or younger?  
   - Yes  - No

7. Have you received a monoclonal antibody (Regeneron or Bamlanivimab) for COVID-19 in the past 90 days?  
   - Yes  - No

8. Are you currently experiencing any of the following:  
   
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever or chills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td></td>
<td></td>
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<tr>
<td>Shortness of breath or difficulty breathing</td>
<td></td>
<td></td>
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<tr>
<td>Fatigue</td>
<td></td>
<td></td>
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<tr>
<td>Muscle or body aches</td>
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<tr>
<td>New loss of taste or smell</td>
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<tr>
<td>Sore throat</td>
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<tr>
<td>Congestion or runny nose</td>
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<tr>
<td>Nausea or vomiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. Have you tested positive for COVID-19 in the last 3 weeks?  
   - Yes  - No

10. Are you currently awaiting results for a COVID-19 test?  
    - Yes  - No

11. Do you have any of the following conditions?  
    - allergies  
    - have a bleeding disorder or are on a blood thinner  
    - are immunocompromised or are on a medicine that affects your immune system  
    - are pregnant or plan to become pregnant  
    - are breastfeeding  
    - Yes  - No

12. If you answered yes to number 11 above, have you spoken to your provider?  
    *If no, then speak to provider  
    - Yes  - No*  - N/A

13. Do you have any dermal fillers  
    - Yes  - No

If YES to any of the above refer to COVID 19 Vaccine Screening protocols

By signing below, I acknowledge that I have received the screener above and certify my answers to be true.

Signature  
Date