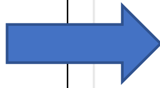
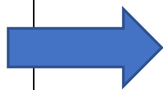
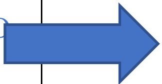
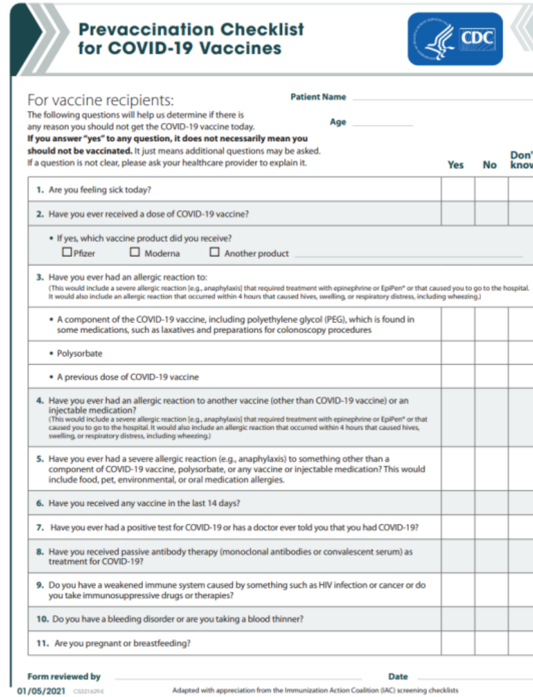
CLICK THE FOLLOWING LINK / HAGA CLIC EN EL SIGUIENTE ENLACE REGISTRATION FOR NOVEMBER 22 CLINIC AT HMS / INSCRIPCIÓN PARA LA CLÍNICA DEL 22 DE NOVIEMBRE EN HMS	PHS Heritage Middle School About Services Contact REQUEST APPOINTMENT Positive Health Services PHS Heritage Middle School Stay Positive! 11 Conti PKWY Elmwood Park, IL 60707 · View office hours · (630) 519-3607 · Send email REQUEST APPOINTMENT Practice Location Heritage Middle School 6850 31rst Berwyn, IL 60402 Choose date and time Sat Apr 24 · Sun Apr 25 · Mon Apr 26 · Tue Apr 27 Next availability: Sat, May 15 Or call our office at (630) 519-3607 to book an appointment. Enter patient information First name · Last name · Phone Number · Email · Date of Birth · Choose gender... · Reason for visit Add Insurance Select payment method REQUEST APPOINTMENT
CLICK **NEXT AVAILABILITY:** Sat, November 22 / HAGA CLIC EN PRÓXIMA DISPONIBILIDAD: Sáb, 22 de noviembre	REQUEST APPOINTMENT Practice Location Heritage Middle School 6850 31rst Berwyn, IL 60402 Choose date and time Thu Nov 11 · Fri Nov 12 · Sat Nov 13 · Sun Nov 14 · Mon Nov 15 No times available for these dates Next availability: **Mon, Nov 22** Or call our office at (630) 519-3607 to book an appointment. Enter patient information First name · Last name · Phone Number · Email · Date of Birth · Choose gender... · Reason for visit Payment Select payment method REQUEST APPOINTMENT

CLICK **APPOINTMENT TIME** FROM LIST / HAGA CLIC EN HORA DE CITA DE LA LISTA 	REQUEST APPOINTMENT **Practice Location** Heritage Middle School 6850 31rst Berwyn, IL 60402 **Choose date and time** Mon Nov 22 · Tue Nov 23 · Wed Nov 24 · Thu Nov 25 · Fri Nov 26 10:00am 10:05am 10:10am 10:15am 10:20am more **Enter patient information** First name · Last name Phone Number · Email Date of Birth · Choose gender... Reason for visit **Payment** Select payment method REQUEST APPOINTMENT
ENTER PATIENT INFORMATION **FIRST NAME** **LAST NAME** **PHONE NUMBER** **EMAIL** **DATE OF BIRTH** **SELECT GENDER /** INGRESE LA INFORMACIÓN DEL PACIENTE **PRIMER NOMBRE** **APELLIDO** **NÚMERO DE TELÉFONO** **CORREO ELECTRÓNICO** **FECHA DE NACIMIENTO** **SELECCIONE EL GÉNERO**	**Enter patient information** First name · Last name Phone Number · Email Date of Birth · Choose gender...

<table>
<tr>
<td>ENTER “VACCINATION CLINIC” IN REASON FOR VISIT BOX / INGRESE "CLÍNICA DE VACUNACIÓN" EN EL CUADRO MOTIVO DE LA VISITA</td>
<td>Enter patient information
JOHN
DOE
(555) 555-5555
JOHNDOE@GMAIL.COM
01/01/2001
Male

Reason for visit</td>
</tr>
<tr>
<td>SELECT “INSURANCE” FROM THE ADD INSURANCE DROP DOWN MENU / SELECCIONE "SEGURO" EN EL MENÚ DESPLEGABLE AGREGAR SEGURO</td>
<td>Add Insurance

Insurance
Insurance Company</td>
</tr>
</table>

TYPE **COVID19** IN THE INSURANCE COMPANY BOX AND SELECT **COVID19 HRSA UNINSURED TESTING AND TREATMENT FUND** / ESCRIBA COVID19 EN EL CUADRO DE LA COMPAÑÍA DE SEGUROS Y SELECCIONE "COVID19 HRSA UNINSURED TESTING AND TREATMENT FUND"	**Add Insurance** Insurance COVID COVID19 HRSA Uninsured Testing and Treatment Fund
ENTER "**0**" IN THE **INSURANCE MEMBER ID** BOX / INGRESE "0" EN EL CUADRO DE IDENTIFICACIÓN DEL MIEMBRO DEL SEGURO	**Add Insurance** Insurance COVID19 HRSA Uninsured Testing and Treatment Fund 0

CLICK “**REQUEST APPOINTMENT**” / HAGA CLIC EN "SOLICITAR CITA"	1514 S. 9th Ave Maywood , IL 60153 View office hours (630) 519-3607 Send email REQUEST APPOINTMENT Practice Location Maywood Mobile Vaccination Clinic 1514 S. 9th Ave Maywood, IL 60153 Choose date and time Wed Apr 21 · Thu Apr 22 · Fri Apr 23 · Sat Apr 24 10:35am · 10:40am · 10:45am · 10:50am · 10:55am · more Enter patient information JOHN · DOE (555) 555-5555 · JOHNDOE@GMAIL.COM 01/01/2001 · Male VACCINATION CLINIC Add Insurance Insurance COVID19 HRSA Uninsured Testing and Treatment Fund 0 REQUEST APPOINTMENT
THE FOLLOWING MESSAGE WILL APPEAR “WE’RE HAVING A PROBLEM VERIFYING THE INSURANCE INFORMATION YOU ENTERED. CONTINUE ANYWAY?” / APARECERÁ EL SIGUIENTE MENSAJE: “TENEMOS UN PROBLEMA PARA VERIFICAR LA INFORMACIÓN DEL SEGURO QUE INGRESÓ. ¿CONTINUE DE TODOS MODOS?” CLICK “**REQUEST APPOINTMENT**” A SECOND TIME / HAGA CLIC EN “**SOLICITAR CITA**” UNA SEGUNDA VEZ YOU WILL RECEIVE A CONFIRMATION MESSAGE AFTER YOU SUBMIT. / RECIBIRÁ UN MENSAJE DE CONFIRMACIÓN DESPUÉS DE ENVIARLO.	1514 S. 9th Ave Maywood , IL 60153 View office hours (630) 519-3607 Send email REQUEST APPOINTMENT Practice Location Maywood Mobile Vaccination Clinic 1514 S. 9th Ave Maywood, IL 60153 Choose date and time Wed Apr 21 · Thu Apr 22 · Fri Apr 23 · Sat Apr 24 10:35am · 10:40am · 10:45am · 10:50am · 10:55am · more Enter patient information JOHN · DOE (555) 555-5555 · JOHNDOE@GMAIL.COM 01/01/2001 · Male VACCINATION CLINIC Add Insurance Insurance COVID19 HRSA Uninsured Testing and Treatment Fund 0 We're having a problem verifying the insurance information REQUEST APPOINTMENT

IF POSSIBLE, PRINT THE “**PREVACCINTATION CHECKLIST FOR COVID-19 VACCINES**” FORM. / SI ES POSIBLE, IMPRIMA EL FORMULARIO "LISTA DE VERIFICACIÓN PREVIA A LA VACUNACIÓN CONTRA EL COVID-19". COMPLETE THE FORM THE DAY OF YOUR APPOINTMENT AND BRING WITH YOU TO YOUR APPOINTMENT. / COMPLETE EL FORMULARIO EL DÍA DE SU CITA Y LLÉVELO CON USTED A SU CITA.	

Prevaccination Checklist for COVID-19 Vaccines

CDC

For vaccine recipients:

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

Patient Name ______

Age ______

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Another product ______			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
• Polysorbate			
• A previous dose of COVID-19 vaccine			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			

Form reviewed by ______ **Date** ______

01/05/2021 CS321629-E Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists 1