WILCOX HEALTH COVID-19 VACCINATION CLINIC

Important Information About Your Appointment.

LOCATION:

Wilcox Medical Center
3-3420 Kuhio Highway
Lihue, HI 96766

Please enter and exit Wilcox Medical Center through the side entrance next to the Infusion Center.

Vaccinations are by appointment only. No walk-ins will be accepted at the vaccination clinic.

ARRIVAL:

Please arrive no earlier than 15 minutes before your scheduled appointment. Patients who arrive too early will be asked to come back closer to their appointment time.

WHAT TO BRING WITH YOU:

1) Picture I.D.

2) Insurance Card

3) Pre-Vaccination Checklist (see next page attached)
If you are able to complete and print the checklist, please do so and bring it to your appointment. If you cannot print this document, we will have them available for you to complete at your appointment.

4) For second dose appointments only, please bring the CDC COVID-19 Vaccination Record Card that was provided to you at your first appointment.

WHAT TO EXPECT DURING YOUR APPOINTMENT:

For your safety and well-being, you will be monitored for any side effects by medical personnel for a minimum of 15 minutes after receiving the COVID-19 vaccine.

Before you leave, you will be asked to schedule your appointment for your second dose.

Please note that everyone entering the facility must have their temperature checked, wear a mask and practice appropriate physical distancing.

PATIENT ESCORTS FOR SPECIAL ASSISTANCE:

Vaccinations are by appointment only. If you require assistance, you may bring one person with you to escort you for your vaccination appointment. This person must be 18 years or older. We will not be able to administer the vaccine to escorts who do not have an appointment.

AGE RESTRICTIONS FOR VISITORS:

Vaccine recipients must be 16 or older. Those age 16 and 17 will need to be accompanied by a parent or a guardian for their vaccine appointment. Please note, children under the age of 18 are not allowed in the vaccination clinic unless they are 16 or 17 and are coming in for an appointment to receive a vaccination.

HAWAIʻI PACIFIC HEALTH | WILCOX HEALTH
CREATING A HEALTHIER HAWAIʻI

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name ______________________

Age ______________

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.
I understand that Hawaii Pacific Health may bill my insurance for vaccine administration.

	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** ______________