LAFENE+ HEALTH CENTER
YOUR STUDENT HEALTH RESOURCE

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myLAFENE+

RISK QUESTIONNAIRE FOR COVID-19 VACCINES

Last Name *(Please print)*	First Name	MI	WID#

Phone Number	Date of Birth	Age

1. Are you 18 years of age or older?	Yes	No
2. Are you employed in a faculty, staff or on-campus student worker position?	Yes	No
3. Do you have any of the following medical conditions? *cancer, chronic kidney disease, chronic obstructive pulmonary disease (COPD), down syndrome, heart conditions (ie. cardiomyopathy, heart failure (coronary artery disease)), immunocompromised state from a solid organ transplant, type 2 diabetes mellitus, sickle cell disease, pregnancy*	Yes	No
4. Do you have any of the following medical conditions? *asthma (moderate-to-severe), cerebrovascular disease, cystic fibrosis, hypertension, neurological conditions, liver disease, pulmonary fibrosis, thalassemia, type 1 diabetes mellitus, obesity (Body Mass Index (BMI) >30), immunocompromised state (from blood or bone marrow transplant, immune deficiencies, HIV, use of chronic corticosteroid medication or other immune weakening meds)*	Yes	No