# COVID-19 Vaccine Registry for Oncology Patients: POCC-V

This survey captures information about children with cancer who have received the COVID-19 vaccine. Clinicians caring for such patients can complete the survey.

We will send you an email reminder in 5 weeks to update your answers if your patient requires a second vaccination.

Fields marked with a red asterisk (*) are required.

If you have any questions, please contact us at:POCCReport@uabmc.edu

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Please enter an identifier (number 1-1000) for your own convenience. This cannot be the patient's MRN, date of birth, or social security number. If this patient has also been entered into the Pediatric Oncology COVID-19 Case Registry (POCC), please use the same local study ID. ________________________

## Information About Person Completing the Survey

Person filling out the survey: (Last, First) ________________________

E-mail address of person filling out the survey: ________________________

Would you like to receive the regular POCC Reports (at least every month while the pandemic is active)?
- ◯ Yes
- ◯ No

May we contact you about future studies about children with cancer and COVID-19?
- ◯ Yes
- ◯ No

Has the patient ever had COVID-19?
- ◯ Yes
- ◯ No
- ◯ Unsure

Have you completed the Pediatric Oncology COVID-19 Case Report (POCC) survey for this patient?
- ◯ Yes
- ◯ No

Approximately how many days between the patient's COVID-19 diagnosis and the first vaccination administration? ________________________

## Vaccine Information:

In what State, Territory, or Province did this patient receive a COVID-19 vaccine?

- ◯ District of Columbia (D.C.)
- ◯ Alabama
- ◯ Alaska
- ◯ Arizona
- ◯ Arkansas
- ◯ California
- ◯ Colorado
- ◯ Connecticut
- ◯ Delaware
- ◯ Florida
- ◯ Georgia
- ◯ Hawaii
- ◯ Idaho
- ◯ Illinois
- ◯ Indiana
- ◯ Iowa
- ◯ Kansas
- ◯ Kentucky
- ◯ Louisiana
- ◯ Maine
- ◯ Maryland
- ◯ Massachusetts
- ◯ Michigan
- ◯ Minnesota
- ◯ Mississippi
- ◯ Missouri
- ◯ Montana
- ◯ Nebraska
- ◯ Nevada
- ◯ New Hampshire
- ◯ New Jersey
- ◯ New Mexico
- ◯ New York
- ◯ North Carolina
- ◯ North Dakota
- ◯ Ohio
- ◯ Oklahoma
- ◯ Oregon
- ◯ Pennsylvania
- ◯ Rhode Island
- ◯ South Carolina
- ◯ South Dakota
- ◯ Tennessee
- ◯ Texas
- ◯ Utah
- ◯ Vermont
- ◯ Virginia
- ◯ Washington
- ◯ West Virginia
- ◯ Wisconsin
- ◯ Wyoming
- ◯ Alberta
- ◯ American Samoa
- ◯ British Columbia
- ◯ Guam
- ◯ Manitoba
- ◯ New Brunswick
- ◯ Newfoundland and Labrador
- ◯ Northern Mariana Islands
- ◯ Northwest Territories
- ◯ Nova Scotia
- ◯ Nunavut
- ◯ Ontario
- ◯ Prince Edward Island
- ◯ Puerto Rico
- ◯ Quebec
- ◯ Saskatchewan
- ◯ U.S. Virgin Islands
- ◯ Yukon

| | |
|---|---|
| Where was this patient vaccinated? | ◯ Pediatric Oncology Office<br>◯ Other |
| Age at first vaccination dose (in years): | __________________ |
| Which vaccine did the patient receive? | ◯ Astra Zeneca<br>◯ Johnson and Johnson (Janssen)<br>◯ Moderna<br>◯ NovaVax<br>◯ Pfizer (Comirnaty)<br>◯ Other<br>◯ Unknown |
| Please specify "other" vaccine administered: | __________________ |
| Will this patient need a second dose of the vaccine? | ◯ Yes<br>◯ No |
| Will this patient need a third dose of the vaccine? | ◯ Yes<br>◯ No |

## First Vaccine Dose:

These next questions relate to the FIRST vaccine dose that the patient received. If the patient requires a second dose, we will reach out to you in 5 weeks to complete these questions for the second dose. If the patient does not require a second dose, please respond to these questions in relation to the only vaccination dose.

| | |
|---|---|
| Did the patient have an allergic reaction to the FIRST vaccination dose? | ◯ Yes<br>◯ No<br>◯ Unknown |
| What allergic reaction(s) did this patient have? (select all that apply): | ☐ Anaphylaxis<br>☐ Angioedema<br>☐ Hives<br>☐ Hypotension<br>☐ Shortness of Breath/Wheezes<br>☐ Other |
| Please describe the "other" allergic reaction: | __________________ |
| Was the patient given medication to alleviate the reaction? | ◯ Yes<br>◯ No<br>◯ Unsure |
| What medication(s) was the patient given for the reaction? (please select all that apply): | ☐ Albuterol<br>☐ Benadryl<br>☐ Bolus<br>☐ Epinephrine<br>☐ Ranitidine/Famotidine<br>☐ Steroids<br>☐ Other |
| Please list the "other" medication used for the allergic reaction: | __________________ |

| | |
|---|---|
| Did this patient require hospital admission for their allergic reaction? | ◯ Yes<br>◯ No<br>◯ Unsure |
| Does this patient have a history of allergic reactions? | ◯ Yes<br>◯ No<br>◯ Unknown |
| What is this patient allergic to? | ☐ Previous Vaccines<br>☐ Pegylated Asparaginase<br>☐ Etoposide<br>☐ Other |
| Please list "other" cause of allergic reaction: | __________________________________ |
| Did this patient experience any side effects from the FIRST administration of the vaccine? | ◯ Yes<br>◯ No<br>◯ Unsure |
| What side effects did the patient experience? (please select all that apply): | ☐ Unsure<br>☐ Abdominal Pain<br>☐ Chills<br>☐ Congestion<br>☐ Cough<br>☐ Excessive Sweating<br>☐ Fatigue<br>☐ Fever<br>☐ Headache<br>☐ Itchiness<br>☐ Joint Pain<br>☐ Myalgias (Muscle Aches)<br>☐ Nausea<br>☐ Pain at Injection Site<br>☐ Rash<br>☐ Swelling at Injection Site<br>☐ Swollen Lymph Nodes<br>☐ Vomiting<br>☐ Other |
| Please describe the "other" side effect(s): | __________________________________________ |
| How long did these side effects last? (please report as number of days): | __________________________________ |

**Second Vaccine Dose:**

These next questions relate to the SECOND vaccine dose that the patient receives. Please answer these questions once the patient receives their SECOND dose. If the patient has not yet received their second dose, we will send you a reminder 5 weeks after you enter in data regarding the FIRST dose.

| | |
|---|---|
| Did the patient have an allergic reaction to the SECOND vaccination dose? | ◯ Yes<br>◯ No<br>◯ Unsure |

| | |
|---|---|
| What allergic reaction did this patient have? (please select all that apply): | ☐ Anaphylaxis<br>☐ Angiodema<br>☐ Hives<br>☐ Hypotension<br>☐ Shortness of Breath/Wheezes<br>☐ Other |
| Please describe the "other" allergic reaction: | __________________________________ |
| Was the patient given medication to alleviate the reaction? | ◯ Yes<br>◯ No<br>◯ Unsure |
| What medication(s) was the patient given for the reaction? (please select all that apply): | ☐ Albuterol<br>☐ Benadryl<br>☐ Bolus<br>☐ Epinephrine<br>☐ Ranitidine/Famotidine<br>☐ Steroids<br>☐ Other |
| Please list the "other" medication used for the allergic reaction: | ____________________________ |
| Did this patient require hospital admission for their allergic reaction? | ◯ Yes<br>◯ No<br>◯ Unsure |
| Did this patient experience any side effects from the SECOND administration of the vaccine? | ◯ Yes<br>◯ No<br>◯ Unknown |
| What side effects did the patient experience? (please select all that apply): | ☐ Unsure<br>☐ Abdominal Pain<br>☐ Chills<br>☐ Congestion<br>☐ Cough<br>☐ Excessive Sweating<br>☐ Fatigue<br>☐ Fever<br>☐ Headache<br>☐ Itchiness<br>☐ Joint Pain<br>☐ Myalgias (Muscle Aches)<br>☐ Nausea<br>☐ Pain at Injection Site<br>☐ Rash<br>☐ Swelling at Injection Site<br>☐ Swollen Lymph Nodes<br>☐ Vomiting<br>☐ Other |
| Please describe the "other" side effect(s): | __________________________________ |
| How long did these side effects last? (please report as number of days): | ____________________________ |

These next questions relate to the THIRD vaccine dose that the patient receives. Please answer these questions once the patient receives their THIRD dose. If the patient has not yet received their third dose, we will send you a reminder 5 weeks after you enter in data regarding the SECOND dose.

## Third Vaccine Dose:

Did the patient have an allergic reaction to the THIRD vaccination dose?

- ◯ Yes
- ◯ No

What allergic reaction did this patient have? (please select all that apply):

- ☐ Anaphylaxis
- ☐ Angiodema
- ☐ Hives
- ☐ Hypotension
- ☐ Shortness of Breath/Wheezes
- ☐ Other

Please describe the "other" allergic reaction:

__________________________________________

Was the patient given medicine to alleviate the reaction?

- ◯ Yes
- ◯ No
- ◯ Unsure

What medication(s) was the patient given for the reaction? (please select all that apply):

- ☐ Albuterol
- ☐ Benadryl
- ☐ Bolus
- ☐ Epinephrine
- ☐ Ranitidine/Famotidine
- ☐ Steroids
- ☐ Other

Please list the "other" medication used for the allergic reaction:

__________________________________

Did this patient require hospital admission for their allergic reaction?

- ◯ Yes
- ◯ No
- ◯ Unsure

Did the patient experience any side effects from the THIRD administration of the vaccine?

- ◯ Yes
- ◯ No
- ◯ Unknown

What side effects did the patient experience? (select all that apply):

- ☐ Unsure
- ☐ Abdominal Pain
- ☐ Chills
- ☐ Congestion
- ☐ Cough
- ☐ Excessive Sweating
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Itchiness
- ☐ Joint Pain
- ☐ Myalgias (Muscle Aches)
- ☐ Nausea
- ☐ Pain at Injection Site
- ☐ Rash
- ☐ Swelling at Injection Site
- ☐ Swollen Lymph Nodes
- ☐ Vomiting
- ☐ Other

Please describe the "other" side effects:

______________________________

How long did these side effects last? (please report as number of days):

______________________________

## Cancer Information:

Patient's cancer diagnosis:

- ◯ Acute lymphocytic leukemia (ALL)
- ◯ Acute myelogenous leukemia (AML)
- ◯ Chronic myelogenous leukemia (CML)
- ◯ Diffuse Intrinsic Pontine Glioma (DIPG)
- ◯ Ependymoma
- ◯ Ewing's Sarcoma
- ◯ Germ Cell Tumor
- ◯ Hepatoblastoma
- ◯ Hodgkin Lymphoma
- ◯ Medulloblastoma
- ◯ Melanoma
- ◯ Neuroblastoma
- ◯ Non-Hodgkin Lymphoma
- ◯ Non-Rhabdo Soft Tissue Sarcoma (NRSTS)
- ◯ Optic Nerve Glioma
- ◯ Osteosarcoma
- ◯ Other Glioma
- ◯ High-Grade Glioma
- ◯ Low-Grade Glioma
- ◯ Retinoblastoma
- ◯ Rhabdomyosarcoma
- ◯ Wilms' Tumor
- ◯ Other

Please specify which cancer diagnosis:

______________________________

Please check whether the patient is receiving therapy for a newly diagnosed disease or relapse/recurrent disease:

- ◯ Newly Diagnosed
- ◯ Relapsed/Recurrent Disease

Has the patient received HSCT?
◯ Yes
◯ No

Information About Transplantation

If known, please include the year of transplant (YYYY): ______________________

If known, please include the number of days between transplant and the first vaccine dose administration: ______________________

Was the transplant autologous or allogenic?
◯ autologous
◯ allogenic

Has the patient ever received GVHD prophylaxis?
◯ Yes
◯ No

What GVHD prophylaxis has the patient received? (please check all that apply)

| | Ever Received | Received at time of COVID-19 vaccine administration |
|---|---|---|
| Abatecept | ◯ | ◯ |
| Alemtuzumab | ◯ | ◯ |
| ATG | ◯ | ◯ |
| CSA | ◯ | ◯ |
| Ex-vivo T-cell depletion | ◯ | ◯ |
| Methylprednisone | ◯ | ◯ |
| MMF | ◯ | ◯ |
| MTX | ◯ | ◯ |
| Post-transplant cyclophosphamide | ◯ | ◯ |
| Tacrolimus | ◯ | ◯ |
| Other | ◯ | ◯ |
| Unknown | ◯ | ◯ |

Please list "other" GVHD prophylaxis: ______________________

Did the patient have active GVHD at the time of the first vaccine dose?
◯ Yes
◯ No

Did the patient have any other HSCT complications around the time of the first vaccine dose administration?
◯ Yes
◯ No

What HSCT complications did the patient have?
◯ IPS
◯ TA-TMA
◯ SOS/VOD
◯ Other

What "other" complication(s) did the patient have? ______________________

Was the patient receiving any medications related to GVHD or other BMT complications within 14 days prior to first vaccine dose administration?

◯ Yes
◯ No

What medications was the patient taking? (check all that apply)

☐ Abatacept
☐ Alemtuzumab
☐ ATG
☐ CSA
☐ Defibrotide
☐ ECP
☐ Eculizumab
☐ Etanercept
☐ FAM-based therapy
☐ Ibrutinib
☐ Imatinib
☐ Infliximab
☐ Lovenox
☐ MMF
☐ MTX
☐ Pentostatin
☐ Rituximab
☐ Ruxolitinib
☐ Sirolimus
☐ Steroids
☐ Tacrolimus
☐ Tocilizumab
☐ Other

Please list the "other" medication taken for GVHD or BMT complications: __________________________________

If you have them, please include the most recent transplant-related labs prior to first vaccine dose administration:

CD4: __________________________________

CD8: __________________________________

CD19: __________________________________

CD56: __________________________________

## Information about Cancer Treatment

Has the patient received chemotherapy in the last year?

◯ Yes
◯ No

Please list the number of days between first vaccine dose administration and start of last cycle of chemotherapy. If the patient was on ongoing chemotherapy at time of COVID-19 diagnosis (e.g daily Sorafenib), please list 0 days: __________________________________

Has the patient received radiation in the last year?

◯ Yes
◯ No

| | |
|---|---|
| Which has the following therapies has the patient ever received? | ☐ Inotuzumab<br>☐ CAR-T<br>☐ Rituximab<br>☐ Blinatumomab<br>☐ The patient has not received any of these<br>☐ Unknown |
| What treatment regimen is guiding this patient's treatment? | __________________________________ |
| What phase of treatment is this patient in? | __________________________________ |

**Patient Demographics:**

| | |
|---|---|
| What is the patient's race? (please select all that apply): | ☐ American Indian/Alaska Native<br>☐ Asian<br>☐ Native Hawaiian or Other Pacific Islander<br>☐ Black or African American<br>☐ White<br>☐ Other<br>☐ Unknown / Not Reported |
| Please list "other": | ____________________________ |
| What is the patient's ethnicity? | ☐ Hispanic or Latino<br>☐ NOT Hispanic or Latino<br>☐ Unknown / Not Reported |
| What is the patient's gender? | ◯ Female<br>◯ Male<br>◯ Other |
| What type of insurance does the patient have? | ◯ Public (including military insurance - e.g. Tricare)<br>◯ Private<br>◯ Other<br>◯ Unknown |
| If other, please specify what type of insurance: | ____________________________ |
| Is there anything else you would like to share about COVID-19 vaccinations in pediatric cancer patients? | __________________________________ |