Iverson Corner Drug COVID-19 <u>Spikevax</u> Questionnaire

(This form is for walk-in vaccinations. It is for patients 18 years old and older only.)

Name: ____

D.O.B.: _______________________________ Gender : _________________________

Phone # : ____________________ Email: ____

Address: ____

City: _________________________________ State________________ Zip ___________________

Questionnaire:

Was your last COVID-19 Vaccine over 2 months ago? Y N

Do you have a weakened immune system caused by something such as HIV, cancer, or immunosuppressive therapy? Y N

Have you ever had an **allergic reaction** to:

Polyethylene Glycol (PEG) or polysorbate? Y N

A previous COVID-19 Vaccine? Y N

Any injectable medication or vaccine? Y N

Have you ever had ANY severe allergic reaction? (Anaphylactic reaction) Y N

Have you received ANY vaccines in the last 14 days, or are you planning to

receive any other vaccine in the next month? Y N

Have you tested positive for COVID-19 in the last 2 months? Y N

If so, did you receive passive antibody therapy (monoclonal
Antibodies or convalescent plasma) ? Y N

Do you have a bleeding disorder, or are taking a blood thinner, or do you have
a history of or a risk factor for a blood clotting disorder? Y N

Are you pregnant or breastfeeding? Y N

I wish to receive a vaccination against COVID-19. I am taking this vaccine voluntarily, and consent to the vaccination being given to me. I have read and understand the information provided in the EUA. I understand the risks and benefits of this vaccine. I have had an opportunity to ask questions which have been answered to my satisfaction. I hereby waive any claim for damages that I (or anyone claiming on my behalf) may have against Iverson Corner Drug, its pharmacists, nurses, directors or employees on account of any injury or misfortune that I may suffer as a result of this vaccination.

Signature:____ Date: ______________________

Lot: ________________ Exp: _____________

Site: R / L Arm Route: Intramuscular Name of vaccinator: ______________________