Davy Crockett Drug

COVID Vaccine Intake Form

*****IMPORTANT NOTICE: Please wear a short sleeve shirt and bring your Medicare card to Pharmacy on day of Vaccination**

Patient Full Name:_____ **Date of Birth:**_____

Home Phone:_____ **Cell Phone:** _____ **Race:**_____

Physical Address:_____ **City:**_____ **Zip:**_____

Primary Physician:_____

	YES	NO
Are you younger than 18 years of age?		
In the past 2-14 days, have you experienced fever or chills, cough, shortness of breath, fatigue, muscle/body aches, headache, new loss of taste of smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea?		
In the past 2-14 days, are you aware of being exposed to someone who tested positive for COVID-19 while not wearing a mask, proper PPE, or socially distanced?		
Have you received any other injections in the last 14 days?		
Have you had immunoglobulin or a blood transfusion in the past 90 days?		
Have you previously tested positive for COVID-19? If so, when? _____		
Have you already had a first dose of COVID-19 vaccine?		
Have you ever had a severe reaction to any vaccine, medication, medical test, or food that required medical care?		
Are you pregnant or planning to get pregnant in the next three (3) months?		
Are you currently breastfeeding?		
Are you immunocompromised or receiving immunosuppressant therapy?		
Are you 65 years of age or older?		

List any diseases you have been diagnosed with:

_____

_____

List any allergies:

_____

_____

☐ I HAVE READ THE INFORMATION ABOUT COVID-19 AND THE COVID 19 VACCINE. I HAVE HAD A CHANCE TO ASK QUESTIONS THAT WERE ANSWERED TO MY SATISFACTION. I BELIEVE I UNDERSTAND THE BENEFITS AND RISKS OF THE VACCINE CITED AND ASK THAT THE VACCINE BE GIVEN TO ME. I UNDERSTAND THAT IT IS RECOMMENDED THAT I STAY ON LOCATION 15 MINUTES FOLLOWING THE INJECTION. I UNDERSTAND A DRUG FACT SHEET FOR THE COVID-19 VACCINE IS AVAILABLE AT
http://www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-recipients.pdf https://www.fda.gov/media/144414/download

Vaccine Dose # 1

Signature: _____ **Date:**_____

Vaccine Dose # 2

Signature: _____ **Date:**_____

Vaccine Dose #1 label

Administered by: _____ Date: _____

Vaccine Dose #2 label

Administered by: _____ Date: _____

Office Use: Dose #1
- ○ IMMTRAC
- ○ Billed Ins

- ○ Medicare card
- ○ Insurance card
- ○ No Insurance

Office Use: Dose #2
- ○ IMMTRAC
- ○ Billed Ins

MC# _____

Name (on MC card): _____