COVID-19 VACCINE ADMINISTRATION SCREENING FORM

Patient Name:	Date of Birth:	Phone:
Address:	City:	State and Zip Code:

Gender: ☐ Female ☐ Male	Allergies:

Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Black/African American ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ Other

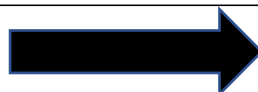
Primary Care Doctor:	Dr. Phone #:

Doctor Address:

What dose of COVID-19 Vaccine are you receiving today?
☐ COVID-19 Dose 1 ☐ COVID-19 Dose 2 ☐ Bivalent Booster
☐ Not sure ☐ Additional Dose Number:

The following questions will help us determine if you are eligible to be vaccinated today.

Question	Answer
1. Are you feeling sick today?	☐ Yes ☐ No ☐ Don't know
2. Have you ever had an allergic reaction to?	
a. A component of the COVID-19 vaccine, including polyethylene glycol (PEG)	☐ Yes ☐ No ☐ Don't know
b. Polysorbate	☐ Yes ☐ No ☐ Don't know
c. A previous dose of COVID-19 vaccine	☐ Yes ☐ No ☐ Don't know
3. Have you ever had a serious reaction after receiving another vaccine or injectable medication?	☐ Yes ☐ No ☐ Don't know
4. Have you ever received a COVID-19 vaccine?	☐ Yes ☐ No ☐ Don't know
a. If so which vaccine did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (J&J)	
b. When was your last dose?	
5. Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?	☐ Yes ☐ No ☐ Don't know
6. Do you have a history of any of the following: Guillain-Barre Syndrome (GBS), Heparin-Induced Thrombocytopenia (HIT), or Myocarditis/Pericarditis?	☐ Yes ☐ No ☐ Don't know
7. Have you received dermal fillers?	☐ Yes ☐ No ☐ Don't know
8. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving a COVID-19 vaccine?	☐ Yes ☐ No ☐ Don't know
9. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID?	☐ Yes ☐ No ☐ Don't know
10. Do you have a bleeding disorder or are you taking blood thinners?	☐ Yes ☐ No ☐ Don't know
11. Are you pregnant or breastfeeding?	☐ Yes ☐ No ☐ Don't know



I certify that I am: (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of Sloan's Pharmacy Inc. to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statement(s) on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Additionally, it is recommended to wait for 15 minutes following the vaccination before leaving the premises. On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by the applicable Provider to the State Registry by using the opt-out form. The Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at Sloan's Pharmacy Inc to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of the people vaccinated at Sloan's Pharmacy Inc, my Primary Care Physician, my insurance and/or state or federal registries, where required, for the purpose of treatment, payment, or other healthcare operations. I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service.

Patient Signature:	Date:
Immunizer Signature:	Administration Date:

Pharmacy Use Only

VACCINE GIVEN:

Vaccine	NDC	Dose	Lot#	Exp. Date	Site of Admin.	Route of Admin.
					LA **RA**	**Intramuscular**