



4426 Kell Blvd • Wichita Falls, TX 76309
940.692.7081 • harvestdrug.com

**COVID-19 Vaccine Screening, Patient
Consent, & Administration Record**

Name: _____

Birthdate: _____ **Phone** _____ **Gender (circle one):** Male / Female

Address: _____

City, State, Zip: _____ **Primary Care Physician:** _____

Race: (Circle One): American Indian/Alaska Native - Asian - Black/African-American - Native Hawaiian/Pacific Islander - White - Other

Ethnicity (Circle One): Hispanic/Latino - Not Hispanic/Latino

- | | | |
|---|-----|----|
| 1. ARE YOU YOUNGER THAN 18 YEARS OF AGE? | YES | NO |
| 2. IN THE PAST 2-14 DAYS HAVE YOU EXPERIENCED SYMPTOMS OF COVID-19 INFECTION? | YES | NO |
| 3. IN THE PAST 2-14 DAYS ARE YOU AWARE OF BEING EXPOSED TO COVID-19? | YES | NO |
| 4. HAVE YOU RECEIVED A DOSE OF COVID-19 VACCINE? | YES | NO |
| IF YES, WHICH PRODUCT DID YOU RECEIVE (circle)? MODERNA J&J PFIZER | | |
| 5. HAVE YOU RECEIVED A COMPLETE COVID-19 VACCINE SERIES (i.e. 1 dose J&J or 2 doses of Pfizer/Moderna) | YES | NO |
| If yes, how long ago since you completed 2 nd dose? _____ | | |
| 6. HAVE YOU HAD IMMUNE GLOBULIN OR A BLOOD TRANSFUSION IN THE PAST 90 DAYS (3 MONTHS)? | YES | NO |
| 7. CHECK ALL THAT APPLY TO YOU: | | |
| <input type="checkbox"/> Female between ages 18 and 49 years old | | |
| <input type="checkbox"/> Male between ages 12 and 29 years old | | |
| <input type="checkbox"/> Have a history of myocarditis or pericarditis | | |
| <input type="checkbox"/> Had a severe allergic reaction to a previous covid vaccine | | |
| <input type="checkbox"/> Had a severe allergic reaction to oral medical, venom, pet, food, or environmental allergies | | |
| <input type="checkbox"/> Diagnosed with MIS-C of MIS-A after a Covid infection | | |
| <input type="checkbox"/> Have a bleeding disorder | | |
| <input type="checkbox"/> Take a blood thinner | | |
| <input type="checkbox"/> Have a history of Heparin induced thrombocytopenia (HIT) | | |
| <input type="checkbox"/> Are currently breastfeeding or pregnant | | |
| <input type="checkbox"/> Have received dermal fillers | | |
| <input type="checkbox"/> History of Guillain Barre Syndrome (GBS) | | |
| <input type="checkbox"/> Have a weakened immune system (HIV, Cancer, ect.) or take immunosuppressive drugs or therapy | | |

Patient Consent: I have read, or have had read to me, the EUA regarding the vaccine I am about to receive. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine. I consent to, or give consent for, the administration of the vaccine and the notification of my primary care physician. I authorize the release of any medical or other information necessary to process this claim. I understand that I should remain in the pharmacy for 15 minutes for observation in case there is an adverse reaction.

Signature: _____ **Date:** _____

FOR OFFICE USE ONLY:

Date	Vaccine	Manufacturer	Lot	Dose	Site	Amt/Admin	EXP Date	Administrator
	COVID-19	Moderna	004M21A	1 st /2 nd /3 rd Booster	RA/LA	0.5 mL IM 0.25 mL IM	07/13/2022	
	COVID-19	J&J	1855190	1 st / Booster	RA/LA	0.5 mL IM	09/24/2022	
	COVID-19	Pfizer	FK9893	1 st /2 nd Booster	RA/LA	0.3 mL IM	05/23/2022	



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