HARVEST
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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 INFECTON?	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 2nd 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:

☐Female between ages 18 and 49 years old
☐Male between ages 12 and 29 years old
☐Have a history of myocarditis or pericarditis
☐Had a severe allergic reaction to a previous covid vaccine
☐Had a severe allergic reaction to oral medical, venom, pet, food, or environmental allergies
☐Diagnosed with MIS-C of MIS-A after a Covid infection
☐Have a bleeding disorder
☐Take a blood thinner
☐Have a history of Heparin induced thrombocytopenia (HIT)
☐Are currently breastfeeding or pregnant
☐Have received dermal fillers
☐History of Guillain Barre Syndrome (GBS)
☐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	046C21A	1st/2nd/3rd	RA/LA	0.5 mL IM	11/6/2021	
	COVID-19	J&J	211A21A	1st	RA/LA	0.5 mL IM	12/14/2021	
	COVID-19	Pfizer	FF2589	1st/2nd/3rd	RA/LA	0.3 mL IM	12/31/2021	