Patient Name: _____ **Facility Name:** _____ **Medicare ID #:** _____

Address: _____ **County:** _____ **Age:** _____ **DOB:** _____

Phone Number: _____ **Injection Site (Circle):** Left Arm or Right Arm

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Another product _____			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
• Polysorbate			
• A previous dose of COVID-19 vaccine			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
9. Do you have a bleeding disorder or are you taking a blood thinner?			
10. Are you pregnant or breastfeeding or considering becoming pregnant in the next month?			
11. Are you of Hispanic, Latino, or of Spanish origin?			
• How would you describe yourself? American Indian or Alaska Native ____ Asian ____ Black or African American ____ Native Hawaiian or other Pacific Islander ____ White ____ Other ____ Prefer not to answer ____			

Patient, Guardian, LTCF Representative Signature: _____

For Pharmacy Use Only:

Date Vaccinated: _____ **Vaccine:** _____ **Site of Admin:** _____

Mfr: _____ **Lot #:** _____ **Exp Date:** _____

Vaccine Administered by: _____

This form is modified from the original CDC document CS321629-E