McDowell's Pharmacy
Since 1901

1004 Main Street
Scotland Neck, NC 27874
Phone: 252-826-4137
Fax: 252-826-4663

COVID-19 Pfizer Screening Form

Name: ________________________________ Date of Birth (MM/DD/YYYY): ____________________

Street Address:_________________________ City:____

State: _________________ Zip Code: __________________ County:________________________

NC Vaccine Group: ____________________________________ Phone: ____________________

Race (Circle the response that applies)
American Indian or Alaskan Native   Asian   African American   Native Hawaiian or Pacific Islander   White
Other Race

Ethnicity	**Gender**
Hispanic or Latino	Male
Not Hispanic of Latino	Female

Mother's Maiden Name:________________________________
Insurance Carrier: ____________________________________ (please provide card)

Only if uninsured: I confirm I do not have any insurance, including but not limited to, Medicare, Medicaid, or any other private or government-funded benefit plan.   Yes   No

Only if uninsured, please provide a copy of your driver's license or other ID card

If you have Medicare, please provide your part B number (from your red, white, and blue card)

Primary Care Provider (write N/A if you do not currently have a provider): _________________________

Emergency Contact Name: __________________________________

Emergency Contact Number: _________________________________

Emergency Contact Relationship: ______________________________

Circle the response that applies:

Are you feeling sick today?	Yes	No
Have you ever received a dose of the COVID-19 vaccine?	Yes	No
Have you ever had a SEVERE allergic reaction one of the following: the COVID-19 vaccine or any component of it [i.e. polyethylene glycol (PEG)] or polysorbate? (Note: if yes, you are NOT eligible to receive the COVID vaccine)	Yes	No

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Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (Note: if yes, you may still receive the vaccine but must be observed for 30 minutes)	Yes	No
Have you ever had a SEVERE allergic reaction (e.g., anaphylaxis) to food, pets, the environment, or oral medications? (Note: if yes, you may still receive the vaccine but must be observed for 30 minutes)	Yes	No
Have you received any vaccine in the last 14 days? (Note: If yes, it is recommended to wait 14 days before receiving the COVID vaccine)	Yes	No
Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? (Note: if yes, it is recommended that you wait until you have recovered/your isolation period has ended before receiving the COVID vaccine)	Yes	No
Have you received passive antibody therapy (Monoclonal antibodies or convalescent serum) as treatment for COVID-19? (Note: If yes, it is recommended to wait 90 days before receiving the COVID vaccine)	Yes	No
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? (Note: If yes, you may still receive the vaccine)	Yes	No
Do you have a bleeding disorder or are you taking a blood thinner? (Note: If yes, you may still receive the vaccine)	Yes	No
Are you pregnant or breastfeeding? (Note: If yes, you may still receive the vaccine)	Yes	No
I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur.	Yes	No
I understand that I will be receiving the vaccination at no cost to me.	Yes	No
If insured, I will bring my prescription and medical insurance cards to my vaccine appointment. I authorize the pharmacy to bill my insurance on my behalf for the immunization. If uninsured, I will bring a copy of my driver's license or provide my SSN.	Yes	No

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to McDowell's Pharmacy and the licensed

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healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the COVID-19 vaccine. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the EUA Fact Sheet on the COVID-19 vaccine 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. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. I understand that I will be receiving the COVID-19 vaccine at no cost to me. I understand that certain COVID vaccines may require 2 doses depending on the manufacturer. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each 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.

Signature: ____ Date: ___________________

For Healthcare Provider(s) Only

Vaccine	Mfg	Expiration	Dosage	Dose (1 or 2)	Admin Site	EUA Fact Sheet Published Date

Clinician's Name: ______________________________ Clinician's Signature: _________________________

Administration Date: ________________________________

Covid-19 Vaccine Lot #: ___________ Covid-19 Vaccine Expiration Date: ________________
Diluent Lot #: __________________ Diluent Expiration Date: _________________________