# COVID-19 Vaccine Screening Form

Last Name: ___________________________ First Name: ____________________________ M.I: ____

DOB: ____ /____ /____ Age: ______ Phone Number: (_____) _____-______

Email: _________________________________ Insurance ID #: ___________________ BIN #: __________

Gender Assigned at Birth: ☐ Male ☐ Female Group #: __________________ PCN#: ______________

Street Address: _______________________________________________ Apt:_______________

City: ___________________________________________ State: ________ Zip Code__________

Please answer the following questions:

**If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

| | | | |
|---|---|---|---|
| Are you feeling sick today? | YES | NO | UNSURE |
| Have you ever received a dose of COVID-19 vaccine? If Yes, on what date(s)? ___/___/___ ___/___/___ | YES | NO | UNSURE |
| *If yes,* which vaccine product?<br>☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another Product: _____________________<br>* Did you bring your vaccination record card or other documentation? (yes/no): ____________ | | | |
| Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital? | YES | NO | UNSURE |
| Was the severe allergic reaction after receiving a COVID-19 vaccine or other Vaccine? | YES | NO | UNSURE |
| Have you received another vaccine in the last 14 days? | YES | NO | UNSURE |
| Have you had a history of Guillain-Barré Syndrome (GBS)? | YES | NO | UNSURE |
| Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? | YES | NO | UNSURE |
| Are you 65 years of age, have underlying medical conditions, or live or work in high-risk settings? | YES | NO | UNSURE |
| Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? | YES | NO | UNSURE |
| Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? | YES | NO | UNSURE |
| Do you have a bleeding disorder or are you taking a blood thinner? | YES | NO | UNSURE |
| Have you had a history of heparin-induced thrombocytopenia (HIT) | YES | NO | UNSURE |
| Do you have a history of myocarditis or pericarditis? | YES | NO | UNSURE |
| Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection? | YES | NO | UNSURE |
| Have you received dermal fillers? | YES | NO | UNSURE |
| Are you pregnant or breastfeeding? | YES | NO | UNSURE |

I acknowledge that I have read or had explained to me the Emergency Use Authorization Fact Sheet for the following COVID-19 vaccine. I have also had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described. I request that the COVID-19 vaccine be given to me or to the person named above for whom I am authorized to make this request.

_______________________________________________________________ ____ /______ /_____

Signature of patient to receive vaccine (or parent, guardian, or authorized representative) Date

For Internal Use Only:

Moderna COVID-19 Vaccine: Lot: _______________ Exp. Date: ______________ VIS/EUA Date: 11/19/2021

Dose: 0.5ml 0.25ml Route: IM Site: LA RA Dose in Series: 1 2 3

Pharmacist Signature: _____________________________________________ Date: _____________