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? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another Product: _____ * 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 Bivalent COVID-19 Vaccine: Lot: _____ Exp. Date: _____ VIS/EUA Date: 04/18/2023

Dose: 0.5ml 0.25ml Route: IM Site: LA RA Dose in Series: 1 2 3 4

Pharmacist Signature: _____ Date: _____