

(Last) _____ (Maiden) _____ (First) _____

(Middle) _____ DOB: ____/____/____ (age) ____

Phone Number: _____ Email: _____

Address: _____ City: _____ State: ____ Zip: _____

Primary Healthcare Provider: _____

Insurance Name: _____ Policy Number: _____

Policy Holder Name: _____ Policy Holder DOB: ____/____/____

Insured Policyholder Employer: _____

COVID-19 Pre-Vaccination Assessment: The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. *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.

	YES	NO	DON'T KNOW
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
<ul style="list-style-type: none"> ● If YES, which vaccine product did you receive? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) Date vaccine received: _____ ● Did you bring your vaccination record card or other documentation? 			
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 caused hives, swelling, or respiratory distress, including wheezing.)			
<ul style="list-style-type: none"> ● A component of the COVID-19 vaccine, including either of the following: <ul style="list-style-type: none"> ○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures ○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids. ● 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 caused hives, swelling, or respiratory distress, including wheezing.)			
5. Check all that apply to you:			
<input type="checkbox"/> I am a female between ages 18 and 49 years old			
<input type="checkbox"/> Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies			
<input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum			
<input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection			
<input type="checkbox"/> Have a weakened immune system (i.e., HIV infection, cancer)			
<input type="checkbox"/> Take immunosuppressive drugs or therapies			
<input type="checkbox"/> Have a bleeding disorder			
<input type="checkbox"/> Take a blood thinner			
<input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT)			

Check all that apply to you:			
<input type="checkbox"/> Am currently pregnant or breastfeeding			
<input type="checkbox"/> Have received dermal fillers			
	YES	NO	DON'T KNOW
6. Will you follow the recommended post-vaccination observation time? (15 or 30 min)			

Consent: I have read or have had explained to me the information provided in the Emergency Use Authorization (EUA) Factsheet or Vaccine Information Statement about COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be administered to me or the person named above for whom I am authorized to make this request.

Signature _____ Date _____

Legal Guardian Signature _____ Date _____

Print Name _____ Relationship to Patient _____

*******STAFF USE ONLY*******

Date Administered	Vaccine Manuf.	Vaccine Lot #	Exp. Date	Fact Sheet date	Dose	Site	Administered By:
__/__/__					0.5ml	Right Left Deltoid	

REACTION: NO YES _____

IRIS Entered: Initial _____ Date _____ Time _____

BILLING: CL0011A (MODERNA 1ST DOSE) CL0012A (MODERNA 2ND DOSE) CL0013A (MODERNA 3RD DOSE)
 CL0001A (PFIZER 1ST DOSE) CL0002A (PFIZER 2ND DOSE) CL0003A (PFIZER 3RD DOSE)
 CL0031A (JANSSEN)