Vaccination Wellness Screening Form

_____ _____/_____/_____

First Name M.I. Last Name Date of Birth (MM/DD/YYYY)

General Screening Questions

Have you been exposed to any person diagnosed with COVID-19? Yes No

Do you live with or interact closely with any individual with a compromised immune system? Yes No

Do you have an objection to wearing a face covering while we provide your immunization? Yes No

Patient Health Assessment

Within the past 14 days, have you experienced any of the following symptoms? (check yes or no)

Sign/Symptom	Yes	No
Fever or chills		
Cough		
Shortness of breath or difficulty breathing		
Fatigue		
Muscle or body aches		
Headache		
New loss of taste or smell		
Sore throat		
Congestion or runny nose		
Nausea or vomiting		
Diarrhea		

Patient: I have had all of my questions answered by the pharmacist and understand the risks and benefits of getting a vaccination today.

_____ _____

Patient Signature Date

Pharmacist: I have reviewed this questionnaire and discussed the risks and benefits of vaccination with my patient.

_____ _____

Pharmacist Signature Date

COVID-19 Vaccine Screening and Consent Form

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Screening Questionnaire	Yes	No
Are you feeling sick today?	☐	☐
Have you been treated with antibody therapy for COVID-19 in the past 90 days	☐	☐
Have you had a serious or life-threatening allergic reaction, such as hives or difficulty breathing to *any* vaccine or shot?	☐	☐
Have you had any vaccines in the past 14 days? (including flu shot)	☐	☐
Are you pregnant, considering becoming pregnant, or breast feeding?	☐	☐
Do you have cancer, leukemia, HIV/AIDS, history of autoimmune disease or any other condition that weakens the immune system?	☐	☐
Do you take any medications that affect your immune system such as steroids, anticancer drugs, or have you had any radiation treatments?	☐	☐

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or licensed vaccine. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent

I have received, read, or had explained to me, and understand the COVID-19 vaccine information sheet provided. I hereby authorize _____ Pharmacy to administer the vaccine I have requested as a two-dose series _____ days apart. I understand that the provider is required to report all COVID vaccine doses to the state Immunization Information System. The scope of this consent includes administration of the vaccine, discussion with a provider if requested, care, and treatments immediately after administration as needed.

_____ _____

Signature Date

COVID-19 Vaccine Administration Record

Please print Today's Date: _____

Section 1: Vaccine Recipient Information

Name: _____ Date of Birth: _____

Phone Number: _____ Gender: ☐ Male ☐ Female

Address: _____
Street

_____ _____ _____
City State Zip

Allergies: ☐No Known Allergies ☐Eggs ☐Latex ☐Other: _____

Medical Conditions: ☐No Known Medical Conditions ☐Asthma ☐High Blood Pressure
☐High Cholesterol ☐Diabetes ☐Pregnancy ☐Other: _____

Race

☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Black or African American
☐ White
☐ Other Race

Ethnicity

☐ Not Hispanic or Latino
☐ Hispanic or Latino

Primary Language

☐ English ☐ Spanish ☐ Other: _____

Primary Healthcare Provider: _____

Section 2: Screening for Vaccine Eligibility

Has the person listed above previously received a COVID-19 vaccine? ☐ Yes ☐ No

If yes to above, Vaccine Brand previously administered: ☐ Pfizer ☐ Moderna
☐ Astra Zeneca ☐ Johnson & Johnson ☐Other: _____

Date first dose administered: Month _____ Day _____ Year _____
Date second dose administered: Month _____ Day _____ Year _____

Section 3: Insurance

Please provide insurance information for the vaccine recipient. For Medicare, please present your red, white, and blue card to the pharmacy staff.

Insurance Company Name: _____

BIN: _____ PCN: _____ Group: _____

ID: _____

Section 4: 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 the COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the COVID-19 vaccine and ask that the vaccine be administered to me or to the person named above for whom I am authorized to make this request.

Signature: _____ Date: _____

Healthcare Provider Use Only

Date Vaccine Administered: _____ Injection Site (IM, Deltoid): ☐ Left ☐ Right

Vaccine: _____ NDC: _____ Dosage: _____ mL

Manufacturer: _____ Lot: _____ Exp: _____

☐ Dose 1 ☐ Dose 2 Diluent Lot: _____ Diluent Exp: _____

_____
Vaccine Administrator Name

_____ _____
Substitution permitted Dispense as written

EUA Factsheet provided on: ☐ Date of Vaccine Administration ☐ Other date: _____

Published date of EUA Factsheet: _____