



COVID VACCINE ADMINISTRATION

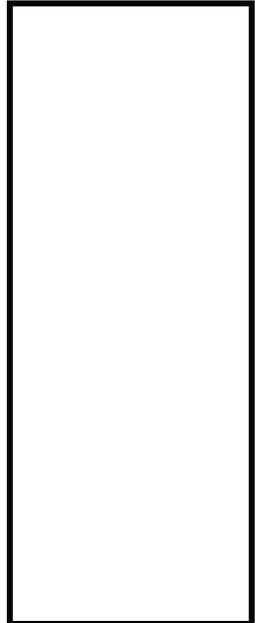
Patient Name: _____ DOB: ____/____/____ Phone #: _____

Address: _____ Sex: M / F Race: _____

FACILITY		ROOM #	
OTHER		OTHER	

A. Fever? Yes / No - Exposure? Yes / No - Symptoms? Yes / No	Yes	No	Don't Know
1. Please circle which arm you would like the vaccine administered LEFT ARM RIGHT ARM			
2. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you previously been diagnosed with Covid-19? If so, what date?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Moderna Vaccine Ingredients include: Nucleoside-modified mRNA encoding the viral spike (S) glycoprotein of SARS-CoV-2, PEG2000-DMG: 1,2-dimyristoyl-rac-glycerol, methoxypolyethylene glycol, 1,2-distearoyl-sn-glycero-3-phosphocholine, Cholesterol, SM-102: heptadecan-9-yl 8-((2-hydroxyethyl) (6-oxo-6-(undecyloxy) hexyl) amino) octanoate, Tromethamine, Tromethamine hydrochloride, Acetic acid, Sodium acetate, Sucrose			
5. Do you have allergies to medications, food, latex or vaccine component?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had Guillain Barre Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any long-term health problems with heart, kidney and/or lung disease, asthma, metabolic disease (e.g. diabetes, anemia or other blood disorder?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, other steroids, anti-cancer drugs, or have you had radiation treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you had a seizure or brain or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Women: Are you pregnant or is there a chance you could be pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever received a shingles vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you had a pneumonia vaccine within the past five years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pharmacists Use:
 Lot: _____
 Exp: _____
 Test: IgG/IgM
 Pharmacist: _____



TEST RESULTS: **NEGATIVE** **POSITIVE**

PHARMACIST SIG: _____

Patient Consent for Vaccination Signature:
 _____ Date: _____

