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?	☐	☐	☐
3.	Have you previously been diagnosed with Covid-19? If so, what date?	☐	☐	☐
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?	☐	☐	☐
6.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
7.	Have you ever had Guillain Barre Syndrome?	☐	☐	☐
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?)	☐	☐	☐
9.	Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?	☐	☐	☐
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?	☐	☐	☐
11.	Have you had a seizure or brain or other nervous system problem?	☐	☐	☐
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?	☐	☐	☐
13.	Women: Are you pregnant or is there a chance you could be pregnant during the next month?	☐	☐	☐
14.	Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
15.	Have you ever received a shingles vaccine?	☐	☐	☐
16.	Have you had a pneumonia vaccine within the past five years?	☐	☐	☐

Pharmacists Use:
Lot:_____

Exp:_____

Test: IgG/IgM

Pharmacist:
_____

Patient Consent for Vaccination Signature:

_____ Date: _____

TEST RESULTS: NEGATIVE ☐ POSITIVE ☐

PHARMACIST SIG: _____