

Your Hometown Pharmacy COVID Vaccine Screening Form

Patient Name: _____ Date of Birth: _____

Cell Phone: _____ Email Address: _____

Street Address: _____ City: _____ Zip: _____

County: _____

Medicare ID: _____ Social Security Number (if uninsured): _____

Pharmacy Card BIN: _____ PCN: _____ GROUP: _____ ID: _____

	YES	NO
Are you younger than 18 years of age?		
Are you 65 years of age or older?		
Have you already had a first dose of COVID-19 vaccine?		
Have you previously tested positive for COVID-19?		
If so, when? _____ RESULT: POSITIVE OR NEGATIVE		
In the past 2-14 days, have you experienced fever or chills, cough, shortness of breath, fatigue, muscle/body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea?		
In the past 2-14 days, are you aware of being exposed to someone who tested positive for COVID-19 while not wearing a mask, proper PPE, or socially distanced?		
Have you received any other injections in the last 14 days?		
Have you had immune globulin or a blood transfusion in the past 90 days?		
Have you ever had a severe reaction to any vaccine, medication, medical test, or food that required medical care?		
Are you pregnant or planning to get pregnant in the next three (3) months?		
Are you currently breastfeeding?		
Are you immunocompromised or receiving immunosuppressant therapy?		

Race/

ethnicity (optional):

- White
- Hispanic or Latino
- Black or African American
- Asian
- American Indian
- Other

I HAVE READ THE INFORMATION ABOUT COVID-19 VACCINE. I HAVE HAD A CHANCE TO ASK QUESTIONS THAT WERE ANSWERED TO MY SATISFACTION. I BELIEVE I UNDERSTAND THE BENEFITS AND RISKS OF THE VACCINE CITED AND ASK THAT THE VACCINE BE GIVEN TO ME. I UNDERSTAND THAT IT IS RECOMMENDED THAT I STAY ON LOCATION 15 MINUTES FOLLOWING THE INJECTION. I GIVE MY CONSENT FOR MY INFORMATION TO BE POSTED ON THE IMMTRAC WEBSITE. I UNDERSTAND A DRUG FACT SHEET FOR THE MODERNA OR JANSSEN COVID-19 VACCINE IS AVAILABLE AT <https://www.fda.gov/media/146305/download?utm%E2%80%94medium=email&utm%E2%80%94source=govdelivery>

Signature: _____ Date: _____

	Janssen	Moderna	Pfizer
Lot#: _____	Expiration: _____	COVID Site (arm): R L	
Administered by: _____		Date: _____	Entered on ImmTrac _____