VACCINE ADMINISTRATION

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

Street: _____City_____St_____Zip_____ Sex: M / F

CHECK THE BOX OF THE VACCINE YOU WANT TO GET TODAY. DO NOT CHECK VACCINES YOU'VE HAD PREVIOUSLY.

Moderna 1st Dose ☐ Pfizer 1st Dose ☐ J&J 1st Dose ☐ FLU SHOT ☐

Moderna 2nd Dose ☐ Pfizer 2nd Dose ☐

Moderna Booster ☐ Pfizer Booster ☐

DO YOU MEET THE GUIDELINES FOR A COVID BOOSTER TODAY? YES ☐ NO ☐

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?	☐	☐	☐
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?	☐	☐	☐

Patient Consent for Vaccination Signature:

_____ Date: _____