COVID-19 Vaccination Form

PLEASE PRINT CLEARLY

First Name	Last Name	Middle Init	DOB / /	Age	Sex M F
Street Address			Other Last Names		
City		State	Zip	Phone	

	Yes	No	Don't Know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
3. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum as a treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor told you that you have had COVID-19?			
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			
10. Are you over the age of 18?			

For use by staff:

Info Rec'd	# In Series	COVID19 Vaccine EUA	Man: Moderna **Lot#:** Exp Date:	Site/Route/Dose **LD RD IM .5cc**	Nurse/PM/EMT Signature	Date Admin.

Vaccination Site: Arlington PD/FD @ Evergreen Fairgrounds

Arlington Fire Department/Police Department
110 E 3rd Street. Arlington, WA 98223