Health Service Pharmacy

634 Eddy Ave.
Missoula, MT 59812
(406)243-5171

Screening Questionnaire for Covid-19 Vaccine

Patient Name (please print legibly): _____

Date of Birth: _____/_____/_____ Phone Number: (_____)_____-_____

Allergies: _____ Male or Female

Home Address:_____

Insurance Information: Bring in a **PHOTOCOPY** of **medical and pharmacy card** (front and back)
BIN:_____PCN_____RxGroup_____Member ID_____
If you have Medicare please use the ID on your Red, White, and Blue Card:_____
Please bring insurance cards to clinic in case we have questions.

Primary Care Provider for records: _____

Yes	NO	
◯	◯	Is the person to be vaccinated sick today? Temperature _____
◯	◯	Have you been diagnosed with Covid-19? If so when? _____
◯	◯	Has the person to be vaccinated ever had a problem from or reaction to any vaccine?
◯	◯	Has the person to be vaccinated ever had an allergy PEG (common in bowel preps)? Allergic to egg products, or feathers?
◯	◯	Is the person to be vaccinated taking any immune suppressing medications? (Example: Prednisone, Chemotherapy, Enbrel)
◯	◯	Is the person to be vaccinated pregnant or breastfeeding?
◯	◯	Has the person to be vaccinated received any vaccines in the **past 14 days**?
NO	**YES**	I understand I will need to stay for **at least 15 minutes** after injection for monitoring.
NO	**YES**	Please circle **yes** or **no** that:

I authorize my health care provider and a public health agency to collect and enter my immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my medical care and treatment. In addition, information may be released to schools in order to comply with immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

Patient Signature: _____ Date: _____
If patient is under 18 years of age, parent/guardian signature is required

Parent/Guardian Signature: _____ Date: _____

Form Reviewed By: _____Date:_____

This section to be completed by the person administering the vaccine

Affix Label with Vaccine Brand, Lot #

and Expiration Date

Injection site (circle one): **Left Deltoid IM**

Dose 1 **Dose 2** **Right Deltoid IM**

Signature of Person Administering Vaccine: _____

Date