

## COVID Vaccine Screening & Administration Record

**For patients:** The following questions will help us determine if there is any reason you should not be given a COVID vaccine today. If you answer "yes" to any questions, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your pharmacist to explain it.

	YES	NO
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction to polysorbate or polyethylene glycol?	<input type="checkbox"/>	<input type="checkbox"/>
4. In the past 14 days have you had confirmed contact with a COVID-19 patient?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you pregnant or breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever received a dose of COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
If so, last vaccine & date: _____		
7. Have received any vaccine in the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
If so, last vaccine & date: _____		

Print Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Drug Allergies: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Primary Care Physician Address: \_\_\_\_\_

I have answered the above questions to the best of my knowledge. My signature below indicates that I have received a "Fact Sheet for Recipients and Caregivers" dated 12/2020 and a written record of today's immunization. *I understand the pharmacy will be sending notification of this vaccine administration to the Missouri ShowMeVax reporting system.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Moderna COVID19 Vaccine      Lot:041B21A

Dose: 0.5 mL    Route: IM    ☐ Left Deltoid    ☐ Right Deltoid

Administered by: Mary Cate Reinert    Cami VanVactor    Alli White    Pharmacist Initials: \_\_\_\_\_

Adverse Reactions Noted: ☐ None    ☐ Other: \_\_\_\_\_

Commercial Ins Processed ☐

Medicare/Medicaid ☐

No Insurance (SSN # on file) ☐