Peoples Drug Store Immunization Screening Questionnaire

Patient Information: First Name: _____ **Last Name:** _____

Date of Birth: _____ **Gender**: ☐ **Male** ☐ **Female** **Phone Number:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

E-mail Address: _____

Please circle one: I am receiving my **(1st dose, 2nd dose)** of the **Moderna** Covid-19 vaccine.

Vaccine Screening:	**YES**	**NO**	**NOT SURE**
1. Are you feeling sick today?			
2. Have you ever had an allergic reaction to a previous vaccine or any of the components of the Moderna COVID-19 vaccine? • This includes a severe reaction (anaphylaxis) leading to the use of an EpiPen or resulting in hospitalization. It also includes allergic reactions that occur within 4 hours that cause hives, swelling, or respiratory distress (wheezing.)			
3. Please list any allergies to food, pets, drugs, etc.			
4. Have you received a vaccine in the last 14 days? • This excludes a first dose of the Moderna COVID-19 vaccine if you are receiving your second dose today.			
5. Have you ever tested positive for COVID-19 or has a doctor ever told you that you had COVID-19?			
• Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
6. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
7. Do you have a bleeding disorder or are you taking a blood thinner?			
8. Are you pregnant or breastfeeding?			
9. Do you have dermal fillers?			

*I have received a copy of the Emergency Use Authorization (EUA) and I have read or have had a pharmacist explain to me the information about the vaccine I am receiving today. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I request this vaccine be given to me or to the person named above for whom I am authorized to make this request.

____ I will remain in at the vaccine site for 15 minutes following my vaccination for observation of an adverse reaction.

Patient Signature: _____ **Date:** _____

For Pharmacist Use: Lot Number:

Admin. Site:_____ Expiration Date:

Administering Pharmacist Signature/Date:

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