Patient Name_____ Date_____Gender: Female Male Prefer Not to Answer

DOB_____ Age _____Phone_____

Allergies _____ (Reactions)_____

Address _____

City_____ State_____ ZIP_____

I, the undersigned, have read or had explained to me the vaccine information sheet (VIS) and/or vaccine fact sheet. I understand the risks and benefits associated with the vaccine and have had any questions satisfactorily answered. I voluntarily request the _____ vaccine(s) to be given for me, or for the aforementioned person for whom I am authorized to make this request.

_____ _____

Signature **Date**

Name and relation if not the patient:_____

ALL VACCINES Screening Questionnaire

1.	Is the person to be vaccinated sick today?	Yes	No	Unknown
2.	Has the person to be vaccinated ever had an allergic reaction to a vaccine or any component of a vaccine?	Yes	No	Unknown
3.	Has the person to be vaccinated ever had a serious reaction after having a vaccination? (Including anaphylaxis or Guillain-Barre syndrome)	Yes	No	Unknown
4.	Has the person to be vaccinated ever had a seizure, a brain, or other nervous system problem?	Yes	No	Unknown
5.	For women: Is the person being vaccinated pregnant or is there a chance you plan to become pregnant in the next month?	Yes	No	Not Applicable
6.	Has the person to be vaccinated received any vaccines in the past 4 weeks?	Yes	No	Unknown

COVID-19 VACCINES ONLY Screening Questionnaire

7.	Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	Yes	No	Unknown
8.	If yes to question #7, which vaccine brand(s) were administered and when was the last dose of vaccine? _____			
9.	Does the person to be vaccinated have a health condition or is undergoing treatment that makes them moderately or severely immunocompromised?	Yes	No	Unknown

10. Check all that apply to the person to be vaccinated:

□ Have a history of myocarditis or pericarditis □ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
□ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A) History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin induced thrombocytopenia (HIT)
□ Have a history of COVID-19 disease within the past 3 months?

Form reviewed by: _____ Date: _____

FOR PHARMACY STAFF USE ONLY

Vaccine product: _____ NDC_____

Exp _____Lot_____Route & Site IM LD/RD Dose 0.3 ml 0.5 ml

Administered by (print) _____ Administration Date _____

Signature_____Credentials-PharmD.

VIS Published date_____ VIS given to patient (date)_____

FOR PHARMACY STAFF USE ONLY

Vaccine product: _____ NDC_____

Exp _____Lot_____Route & Site IM LD/RD Dose 0.5ml

Administered by (print) _____ Administration Date _____

Signature_____Credentials-PharmD.

VIS Published date_____ VIS given to patient (date)_____

FOR PHARMACY STAFF USE ONLY

Vaccine product: _____ NDC_____

Exp _____Lot_____Route & Site IM LD/RD Dose 0.5 ml

Administered by (print) _____ Administration Date _____

Signature_____Credentials- PharmD.

VIS Published date_____ VIS given to patient (date)_____

FOR PHARMACY STAFF USE ONLY

Vaccine product: _____ NDC_____

Exp _____Lot_____Route & Site IM LD/RD Dose 0.5ml

Administered by (print) _____ Administration Date _____

Signature_____Credentials_____

VIS Published date_____ VIS given to patient (date)_____