COVID-19 VACCINATION SCREENING FORM

ATWOOD FAMILY MEDICAL CENTER
CHESAPEAKE EXECUTIVE FAMILY CARE

PATIENT'S NAME _____ DOB: _____

Vaccine recipients: The following questions will help us determine if there is any reason you should NOT get the COVID-19 vaccine today. **If you answer "yes" to any questions, it does not necessarily mean you should not be vaccinated.** It does mean additional questions may be asked. If a question is unclear, please ask so we can provide you with an explanation.

	Yes	No	Don't Know
1. Are you feeling sick today?			
2. Have you received a dose of the COVID-19 vaccine?			
• If yes, which vaccine product did you receive? □ Pfizer □ Moderna □ Another Product _____			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen© or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures.			
• Polysorbate			
• A previous dose of COVID-19 vaccine			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen© or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something other than a component of COVID-19 vaccine polysorbate, or any vaccine or injectable medication? This would include food, pet, environment, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer, or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			

I confirm I have received and read the Moderna EUA for recipients _____

(please initial)

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I agree to wait 15 minutes at Atwood Family Medical Center after receiving my COVID-19 vaccine.

Patient/Guardian's Name: _____ (print name)

Patient/Guardian's Signature: _____

OFFICE USE ONLY:
Patient consent form signed: YES NO

Location of injection: R L DELTOID

Amount given: 0.5 mL

Product: Moderna Lot No. _____

Date of Injection: _____ Person Giving Injection: _____

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