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| --- | --- | --- | --- |
| First name: | MI: | Last name: | |
| Phone #: | DOB: | Age: | Gender: **M** **F** |
| Home address: | City: | State: | Zip Code: |
| Primary Care Physician: | Phone #: | Fax #: | |
| Address: | City: | State: | Zip Code |

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| --- | --- | --- |
| **SCREENING QUESTIONAIRE: Please answer questions by checking the box** | **Yes** | **No** |
| 1) Have you had any vaccines in the past 14 days *or* plan to receive any in the next month?  **If yes, which one(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |
| 2) Have you had the vaccine (s) you are receiving today before?  **If yes, which vaccine product did you receive? \_\_\_\_Moderna \_\_\_\_Pfizer \_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |
| 3) Do you currently have a fever (≥100°F), respiratory illness, or any other type of infection? |  |  |
| 4) Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?  **If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |
| 5) Do you have allergies to medications, food or vaccines?  **If yes, allergies** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 6) Have you ever had a serious reaction after receiving an immunization? (swelling, trouble breathing, seizure, etc.) |  |  |
| 7) Do you have an illness that affects your immune system *or* are you on immunosuppressive therapy (chemotherapy or radiation), including high dose corticosteroids (>20mg/day of prednisone or equivalent)? |  |  |
| 8) Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? |  |  |
| 9) **For women**: Are you pregnant or breastfeeding? |  |  |
| 10) Have you had a mastectomy? **Right or Left** |  |  |
| 11) Do you have a bleeding disorder or are you taking a blood thinner? |  |  |

I have read or have had explained to me the information in this pamphlet about COVID-19 and the COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the EUA and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request. I waive and release all claims I, or anyone claiming by or through me, now have or may hereafter acquire Dr. Paul Murphy, Senior Care Pharmacy, and their respective employees for any damage or injuries if I, or the person named below for whom I am authorized to make this request, contract COVD-19, other diseases, or suffer any other adverse reactions following administration of this vaccine. I understand that I may be held responsible for charges that are not covered by my insurance. I understand that if I do not provide the proper insurance information, I may also be held responsible for charges. For Medicare Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party that accepts assignment. I consent to inclusion of this immunization data in the “Kansas Immunization Registry” for myself or on behalf of the person named. X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
**SIGNATURE OF PERSON TO RECEIVE THE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST (PARENT/GUARDIAN) DATE  
------------------------------------------------------------------------------------------------FOR OFFICE USE ONLY ----------------------------------------------------------------------------------------------------------**

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| --- | --- | --- | --- | --- |
| IMMUNIZER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RPh/Intern | | DATE OF ADMINISTRATION: | EUA FACTSHEET PROVIDED: YES NO | |
| MODERNA 0.5 ML | LOT #: | EXP DATE: | ROUTE: IM | SITE OF INJECTION:  LA or RA |
| PFIZER 0.3 ML | LOT #: | EXP DATE: | ROUTE: IM | SITE OF INJECTION:  LA or RA |
| JANSEN/J&J 0.5ML | LOT # | EXP DATE: | ROUTE: | SITE OF INJECTION  LA or RA |

Pfizer Diluent Lot #/Exp Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| IMMUNIZER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RPh/Intern | | DATE OF ADMINISTRATION: | EUA FACTSHEET PROVIDED: YES NO | |
| MODERNA 0.5 ML | LOT #: | EXP DATE: | ROUTE: IM | SITE OF INJECTION:  LA or RA |
| PFIZER 0.3 ML | LOT #: | EXP DATE: | ROUTE: IM | SITE OF INJECTION:  LA or RA |

Pfizer Diluent Lot #/Exp Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_