Required Information

- Updated Insurance Card (Rx with BIN#)
- Medicare Card (Red, White, & Blue card)
- Valid Driver's License
- Social Security Number

COVID-19 Vaccination Screening Form

***** Please complete the following and provide a copy of all required information before scheduling appointment *****

Patient Information:		
Name:	**DOB:**	**Age:**
Race/Ethnicity: ☐ White ☐ African American ☐ Hispanic/Latino ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander		
Address:	**City/State/Zip:**	
Phone:	**Social Security Number:**	
Drug Allergies:		

Patient Conditions: Please check the box if you have any of the following

☐ Diabetes ☐ Hypertension ☐ COPD ☐ Moderate-severe Asthma ☐ Pulmonary Fibrosis
☐ Obesity BMI ≥ 30 ☐ Chronic Renal Disease ☐ Heart Failure ☐ Coronary Artery Disease ☐ Cardiomyopathies
☐ Liver Disease ☐ Sickle Cell or Thalassemia ☐ Stroke ☐ Cerebrovascular Disease ☐ HIV/AIDs
☐ Immunosuppressed (requiring daily steroids, chemotherapy, or other immunosuppressive medications)

☐ Other (Please Explain): _____

Please answer the following:

1.	Are you feeling sick today?	☐ YES ☐ NO
2.	Do you have any allergies to any medications? If so, please list _____	☐ YES ☐ NO
3.	Are you pregnant, plan to become pregnant, or breastfeeding?	☐ YES ☐ NO
4.	Have you ever had a serious reaction to anything in the past? If yes, what was the reaction to and what was the reaction? _____	☐ YES ☐ NO
5.	Do you have a bleeding disorder or are you taking a blood thinner?	☐ YES ☐ NO
6.	Do you have a weakened immune system from a medical condition or take medications that affect your immune system?	☐ YES ☐ NO
7.	Have you received another vaccine in the last 14 days?	☐ YES ☐ NO
8.	Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐ YES ☐ NO
9.	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐ YES ☐ NO
10.	Have you ever received a dose of COVID-19 Vaccine? If yes, which vaccine product? ☐ Pfizer-BioNTech COVID-19 Vaccine Date of last dose: _____ ☐ Moderna COVID-19 Vaccine	☐ YES ☐ NO

Please check the box in agreement with the following statement:

☒ I have been given a copy and have read, or have had explained to me, the information in the Moderna EUA Fact Sheet for the COVID-19 Vaccination. I understand that the FDA has authorized the emergency use of the COVID-19 vaccine, which is not a FDA-approved vaccination. I understand the potential risks and benefits of the vaccine as explained in the Moderna EUA Fact Sheet and that some risks and benefits remain unknown. I have had the chance to ask questions and were answered to my satisfaction.

☒ I understand the vaccination requires two (2) doses of the same vaccine spaced four (4) weeks apart. I agree that I will stay in the vaccination administration area for at least fifteen (15) minutes or longer (as indicated by the administrator) after receiving my vaccination to ensure no immediate adverse reactions occur and I understand if I experience any adverse reaction, it is my responsibility to follow up with my primary care physician. I hereby request the COVID-19 vaccination be given to me.

1st Dose Patient Signature X_____ **Date:**_____

2nd Dose Patient Signature X_____ **Date:**_____

Notes:

_____

_____

_____

_____

_____

How did you do on your first dose? Check the following:

☐ Injection Site Pain
☐ Injection Site Swelling
☐ Fever
☐ Chills
☐ Feeling Tired
☐ Headache
☐ Muscle Pain
☐ Nausea

☐ Other (Please Specify):

_____

_____

_____

_____

☐ No issues with first dose

Have you had the following vaccinations?	Yes	No	Not Sure
1. Pneumonia vaccinations? *(Prevnar 13 & Pneumovax 23)* • Age 65 and older – Prevnar 13 and then Pneumovax 23 one year later • 64 and younger – Pneumovax 23 based on underlying health conditions			
2. Shingles vaccine? *(Shingrix – two doses spaced 2 – 6 months apart)* • Age 50 and older			
3. Tdap (Tetanus, diphtheria, and pertussis) • Adults should receive a booster dose every 10 years, or earlier in the case of a severe and dirty wound or burn			

Baggett Pharmacy is now offering COVID-19 Antibody Testing!

Antibody testing can determine your body's production of antibodies to the SARS-CoV2 virus. Recommended 28 days after your vaccination, the production of antibodies indicate your ability to fight off the virus.

Do you want one of our staff members to contact you about antibody testing after your 2nd Vaccination?

☐ Yes please! ☐ No, Thank you.

FOR PHARMACY USE ONLY

Vaccine Administered	Lot Number:	Exp. Date
Moderna COVID-19 Vaccine – 1st Dose		
Moderna COVID-19 Vaccine – 2nd Dose		

Route: Intramuscularly **Dose:** 0.5mL **Site 1st Dose** : L. Deltoid R. Deltoid **Site 2nd Dose:** L. Deltoid R. Deltoid

Dose in Series: **1st Dose** *(Given _____ /_____/_____)* **2nd Dose** *(Given _____ /_____/_____)*

Administering Pharmacist 1st Dose X_____ **Date Given:** _____

Administering Pharmacist 2nd Dose X_____ **Date Given:** _____