FOXHALL INTERNISTS COVID-19 VACCINE FORM

Last Name:	First Name:
DOB:	Primary Care Provider:

SCREENING FOR VACCINATION ELIGIBILITY

	YES	NO	?
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Johnson and Johnson/Janssen			
3. Have you ever had a severe allergic reaction (anaphylaxis, required Epipen use, or hospitalization) _OR_ serious allergic reaction within 4 hours (hives, swelling, respiratory distress/wheezing) to:			
• Polyethylene glycol (PEG), which is found in some medications such as laxatives and colonoscopy preparation medications			
• Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids			
• A previous dose of COVID-19 vaccine			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but the component that elicited the reaction is unknown			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or to an injectable medication? (This includes anaphylaxis, Epipen use, or hospitalization _OR_ involved a serious allergic reaction within 4 hours that included hives, swelling, respiratory distress/wheezing.)			
5. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to food, pet, venom, environmental or oral medication?			
6. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
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 any vaccine in the last 14 days?			
9. Are you pregnant or breastfeeding?			
10. Do you have dermal fillers?			

CONSENT FOR VACCINATION

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization Fact Sheet provided to me today. I understand the benefits and risks of the vaccine.

The vaccine checked above should be given to the person named above for whom I am authorized to make this request. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

Signature of Patient/Legal Representative:____ Date:______________________

FOR ADMINISTRATIVE USE ONLY

Vaccine COVID-19	Date Vaccination and EUA Given	Route: IM L R	Manufacturer: ModernaTX	Lot No	Vaccinator Name and Signature