COVID-19

Vaccination Screening Questionnaire & Consent Form

Patient Data:

First Name		Last Name	
Date of Birth		Gender / Race	/
Address		Phone Number	
City, State, Zip Code		Insurance Provider	
Insurance ID #		RxBin # / Rx Group	

Please answer the following questions - if you have any concerns please discuss these with your vaccination provider

	Yes	No
1. Have you received a COVID-19 vaccine in the past? **WHEN …..**		
3. Have you had anaphylaxis following any vaccination in the past?		
4. Have you had a severe reaction following any vaccination in the past?		
5. Do you feel unwell today?		
6. Do you have cancer, leukemia, AIDS, or any other immune system problem?		
7. Do you have an allergy to eggs?		
8. Are you currently immune-compromised or on a medication that affects your Immune system?		
9. Do you have a bleeding disorder or on a blood thinner medication?		
10. Do you have a severe allergy to anything?		
11. Do you have a neurological disorder such as seizures or other disorders that affect the brain or have had a disorder that resulted from a vaccine (e.g. Guillain-Barre syndrome)		
12. Are you pregnant or could you become pregnant in the next three months or breast feeding?		

I,..……*(PRINT NAME)* consent to have the COVID-19 vaccination and declare that:

* I have read (or it has been read to me) and I understand the "COVID-19 Vaccine Fact Sheet **(VFS)".** I have had the opportunity to ask questions and to have them answered to my satisfaction.

* I consent to be vaccinated with the COVID-19 vaccine. I fully release and discharge Dupont Circle Pharmacy, its officers and employees from any liability for illness, injury, loss, or damage which may result there from.

Signed …….. Date …….

Vaccination details (Pharmacy Staff Use Only)

Date of vaccination..... Time of vaccination..... Site L / R Deltoid *(please circle)*

Name of Vaccine: … Lot#: ……..... Expiry Date…….....

Name of pharmacist who administered Vaccine(s):_____Signature: ____