Owl Drug Pharmacy COVID Vaccine Screening and Consent Form

Patient Name:_____ **Date of Birth:**_____ **Phone:**_____

Address:_____ **City:**_____ **Zip:**_____ **Primary Physician:**_____

What is your front-line healthcare job description or title? (doctor, nurse, etc): _____

	YES	NO
Are you younger than 18 years of age?		
In the past 2-14 days, have you experienced fever or chills, cough, shortness of breath, fatigue, muscle/body aches, headache, new loss of taste of smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea?		
In the past 2-14 days, are you aware of being exposed to someone who tested positive for COVID-19 while not wearing a mask, proper PPE, or socially distanced?		
Have you received any other injections in the last 14 days?		
Have you had immune globulin or a blood transfusion in the past 90 days?		
Have you previously tested positive for COVID-19?		
If so, when? _____		
Have you already had a first dose of COVID-19 vaccine?		
Have you ever had a severe reaction to any vaccine, medication, medical test, or food that required medical care?		
Are you pregnant or planning to get pregnant in the next three (3) months?		
Are you currently breastfeeding?		
Are you immunocompromised or receiving immunosuppressant therapy?		
Are you 65 years of age or older?		

List any diseases you have been diagnosed with:

_____

_____

Do you have any of the following conditions? Check all that apply:

☐ Cancer ☐ Chronic Kidney Disease ☐ COPD ☐ Heart Conditions ☐ Solid Organ Transplantation

☐ Obesity (BMI of 30 or Higher) ☐ Pregnancy ☐ Sickle Cell Disease ☐ Type 2 Diabetes Mellitus

List any prescriptions and/or over the counter medications you take routinely:

_____

_____

_____

List any drug allergies:

_____

_____

Race/ethnicity (optional):
□ White □ Hispanic or Latino □Black or African American □Asian □American Indian
□ Other_____

□ I HAVE READ THE INFORMATION ABOUT COVID-19 AND THE MODERNA 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 VACCINE CITED AND ASK THAT THE VACCINE BE GIVEN TO ME. I UNDERSTAND THAT IT IS RECOMMENDED THAT I STAY ON LOCATION 15 MINUTES FOLLOWING THE INJECTION. I UNDERSTAND A DRUG FACT SHEET FOR THE MODERNA COVID-19 VACCINE IS AVAILABLE AT http://www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-recipients.pdf .

Signature: _____ Date:_____

Moderna Lot#:_____ COVID Site: R L

Expiration #:_____ Dose: 1st 2nd

Administered by:_____ Date: _____