Madison Regional Health System
Additional Dose COVID Vaccination Clinic Form (Please Print Clearly)

First Name ________________________ Last Name _______________________________

Date of Birth ________________ Sex ________ Age _______ Primary Provider name _______________

Address ______________________________________City_____________State_________Zip Code_______

Race _______ Ethnicity ___________ Phone # _________________ Employer __________________________

***For Minors Only*:**

Emergency Contact Name_____________________________ Emergency Contact Phone #________________

Guardian Signature____

Questions?	Yes	No	Don't Know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine? If so, which vaccine product? Pfizer / Moderna / Janssen			
3. Has it been at least 28 days since completing the initial two dose mRNA COVID-19 vaccine series?			
4. Have you ever had a severe allergic reaction to something? Required treatment with Epinephrine or had to go to the hospital?			
a. *Was the allergic reaction after receiving a COVID-19 vaccine?			
b. *Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
5. Do you have a bleeding disorder or are you taking a blood thinner?			
6. Have you ever tested positive for COVID -19 and received passive antibody therapy as treatment for COVID-19? (Monoclonal or Convalescent plasma infusions)			

For office use only below

Additional dose injection of series Date: _______________

Consent _______ *V-Safe* _________ *EUA given* _______ Manufacturer Pfizer/Moderna

Lot # _____________ Vaccine expiration date __________ Injection Site ________________

Administered by ____________

Documentation: SDIIS _______ Order entered _______ Administered on eMAR _______