Madison Regional Health System

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 _____

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. 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?			
4. Do you have a bleeding disorder or are you taking a blood thinner?			
5. 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

First injection of series Priority Group _____ Date: _____

Consent _____ *V-Safe* _____ *EUA given* _____ Manufacturer Pfizer/Moderna/Janssen

Lot # _____ Vaccine expiration date _____ Injection Site _____

Administered by _____ *Second dose schedule date* _____

Documentation: SDIIS _____ Order entered _____ Administered on eMAR _____

Second injection of series Date_____ *EUA given* _____

Side effects of *1st dose*_____ *Consent* _____

Manufacturer Pfizer/Moderna Lot # _____ Vaccine expiration date _____

Injection Site _____ Administered by _____

Documentation: SDIIS _____ Order entered _____ Administered on eMAR _____
