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 tested positive for COVID -19 and received passive antibody therapy as treatment for COVID-19? (Bamlanivumab or Convalescent plasma infusions)			
6. Have you received any vaccine in the past 14 days? (Instruct not to get vaccines other than COVID within the next 14 days)			

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 _____

Documentatikaon: SDIIS _____ Order entered _____ Administered on eMAR _____
