CONLEY'S DRUG STORE EST. 1880

Today's Date_____

VACCINE REGISTRATION FORM

LAST NAME:_____

FIRST NAME:_____ MIDDLE:_____

DATE OF BIRTH:_____GENDER:_____

STREET ADDRESS:_____

CITY/TOWN:_____STATE:_____ZIP:_____

PHONE:_____ EMAIL:_____

RACE: American Indian or Alaska Native Asian

Black or African American White Other Race

Native Hawaiian or Other Pacific Islander

HISPANIC/LATINO: YES NO

INSURANCE: MEDICARE ***B*** MASSHEALTH PRIVATE NONE

Complete this section for COVID vaccinations

COVID-19 TYPE TODAY (circle one): PFIZER/COMIRNATY (Age 12+) MODERNA (age 18+)

Pfizer Pediatric (Age 3-4) Pfizer Pediatric (Age 5-11) Moderna Pediatric (Age 3-5)

J&J (age 18+)

DOSE NUMBER: 1ST Shot 2ND Shot 3rd-Immunosuppressed

1st Booster 2nd Booster

INJECTION SITE: LEFT Deltoid RIGHT Deltoid

Pharmacy Use Only

Vaccine Lot/Exp_____

Administered By_____

PLEASE BE AWARE

There is a 15 minute observation period after your vaccine

For patients to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child a vaccination today. If you answer "yes" to any question it does not necessarily mean you (or you child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Complete if receiving a COVID vaccination today

	Y	N	Don't Know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• Have you received a complete COVID-19 vaccine series *(i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna])*?	☐	☐	
• Did you bring your vaccination record card or other documentation?	☐	☐	
3. Have you ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following: o Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
o Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
4. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré Syndrome (GBS)

Form reviewed by_____Date_____