



VACCINE REGISTRATION FORM

LAST NAME: _____ TODAY'S DATE _____

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

If here for a COVID vaccination complete this section. If not, leave it blank.

COVID-19 TYPE TODAY: PFIZER 12+ PFIZER 3-4 PFIZER 5-11 Novavax(12+, Fri)
MODERNA (Primary 12+,Booster 18+) MODERNA 3-5 MODERNA 6-11 J&J 18+
DOSE: Primary 1st Primary 2nd Primary 3rd Booster

INJECTION SITE: LEFT Deltoid RIGHT Deltoid

Pharmacy Use Only
Vaccine Lot/Exp _____
Administered By _____

PLEASE BE AWARE
There is a required in-store
15-minute observation period
after your vaccine

If here for a FLU vaccination complete this section. If not, leave it blank.

INFLUENZA TYPE: High Dose Ages 65+ (Fluad) Regular Flu Vaccine

INJECTION SITE: LEFT Deltoid RIGHT Deltoid

Pharmacy Use Only
Vaccine Lot/Exp _____
Administered By _____

Name: _____

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever received a dose of COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> If yes, which vaccine product did you receive? <ul style="list-style-type: none"> <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> 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? 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had an allergic reaction to:			
<i>(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.)</i>			
<ul style="list-style-type: none"> A component of a COVID-19 vaccine, including either of the following: <ul style="list-style-type: none"> <input type="checkbox"/> Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures <input type="checkbox"/> Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids A previous dose of COVID-19 vaccine 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(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.)</i>			
5. Check all that apply to you:			
<input type="checkbox"/> Am a female between ages 18 and 49 years old			
<input type="checkbox"/> Am a male between ages 12 and 29 years old			
<input type="checkbox"/> Have a history of myocarditis or pericarditis			
<input type="checkbox"/> Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies			
<input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum			
<input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection			
<input type="checkbox"/> Have a bleeding disorder			
<input type="checkbox"/> Take a blood thinner			
<input type="checkbox"/> Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies			
<input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT)			
<input type="checkbox"/> Am currently pregnant or breastfeeding			
<input type="checkbox"/> Have received dermal fillers			
<input type="checkbox"/> History of Guillain-Barré Syndrome (GBS)			

Complete if receiving a FLU vaccination today

- | | | | |
|--|-----|----|------------|
| 1. Is the person to be vaccinated sick today? | Yes | No | Don't Know |
| 2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine? | Yes | No | Don't Know |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | Yes | No | Don't Know |
| 4. Has the person to be vaccinated ever had Guillain-Barré syndrome? | Yes | No | Don't Know |

Form reviewed by _____ Date _____