Today's Date_____

CONLEY'S EST. 1880 DRUG STORE

# VACCINE ADMINISTRATION RECORD

NAME (Last, First):_____

DATE OF BIRTH:_____ AGE:_____ GENDER:_____

STREET ADDRESS:_____

CITY/TOWN:_____STATE:_____ZIP:_____

PHONE:_____ EMAIL:_____

## PLEASE CIRCLE YOUR SELECTIONS

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

**WOULD YOU LIKE 8 AT-HOME COVID TEST KITS IF COVERED BY INSURANCE? YES NO**

Which COVID vaccine would you like? Additional questions on back

**COVID-19 TYPE**: PFIZER MODERNA

DOSE: PRIMARY SERIES **BIVALENT** BOOSTER

INJECTION SITE: LEFT ARM RIGHT ARM

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Complete this section if you want a **FLU** vaccination. Leave blank if you do not.

**INFLUENZA TYPE**: Senior 65+ Dose Regular Dose

INJECTION SITE: LEFT ARM RIGHT ARM

1. Are you feeling sick today?.....YES NO UNSURE
2. Do you have an allergy to an ingredient in the vaccine?.....YES NO UNSURE
3. Have you ever had a serious reaction to influenza vaccine in the past?.....YES NO UNSURE
4. Have you ever had Guillain-Barré syndrome?.....YES NO UNSURE

# VACCINE ADMINISTRATION RECORD

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked

Patient Name_____ Age_____

| | YES | NO | UNSURE |
|---|---|---|---|
| 1. Are you feeling sick today? | | | |
| 2. Have you completed a PRIMARY SERIES (first 2 doses) of COVID-19 vaccine?<br>Pfizer Moderna Another Product_____ | | | |
| 3. Have you ever had an allergic reaction to:<br>(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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) | | | |
| • A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures | | | |
| • Polysorbate | | | |
| • 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?<br>(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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) | | | |
| 5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies. | | | |
| 6. Have you had COVID-19 disease within the last 3 months?<br>(If yes, you may still get a COVID-19 vaccine today) | | | |
| 7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? | | | |
| 8. Do you have a bleeding disorder or are you taking a blood thinner? | | | |
| 9. Are you pregnant or breastfeeding? | | | |

Form Reviewed by_____ Date_____