DATE: _____          FULL NAME : _____

# COVID-19 VACCINE FORM

ALEXANDRIA
COMPOUNDING
PHARMACY

Please bring the following information and documents to Appointment:
- ☐ Completed COVID-19 Vaccine Screening Form
- ☐ Driver's License or Identification
- ☐ Prescription Insurance Card and/or Medicare Card (if available, if you do not have prescription insurance there will not be a copay)

## (Must be filled out completely)
## Please Print

Last Name: _____          FirstName:_____M.I: _____

DOB:_____/_____/_____          Age: _____          Phone Number: (_____)_____-_____

Email: _____

Gender Assigned at Birth:          Male          Female

Street Address: _____          Apt: _____

City: _____          State: _____          Zip Code: _____

Race:    Caucasian          African American          Hispanic          Asian          American Indian          Pacific Islander          Other
*Please circle*

## Please answer the following questions:

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. If a question is not clear, please ask your healthcare provider to explain it.

| | | | |
|---|---|---|---|
| Are you feeling sick today? | YES | NO | UNSURE |
| Have you ever received a dose of COVID-19 vaccine? | YES | NO | UNSURE |
| *If yes,* which vaccine product? (circle) Pfizer BioNTech COVID-19 Vaccine_____  Moderna COVID-19 Vaccine_____Another Product: _____ | | | |
| Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital? | YES | NO | UNSURE |
| Was the severe allergic reaction after receiving a COVID-19 vaccine? | YES | NO | UNSURE |
| Was the severe allergic reaction after receiving another vaccine or another injectable medication? | YES | NO | UNSURE |
| Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? | YES | NO | UNSURE |
| Have you received another vaccine in the last 14 days? | YES | NO | UNSURE |
| Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? | YES | NO | UNSURE |
| Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? | YES | NO | UNSURE |
| Do you have a bleeding disorder or are you taking a blood thinner? | YES | NO | UNSURE |
| Are you pregnant or breastfeeding? | YES | NO | UNSURE |

DATE: _____ FULL NAME : _____

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I acknowledge that I have read or had explained to me the Emergency Use Authorization Fact Sheet for the following COVID-19 vaccine. Ihave also had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described. I request that the COVID-19 vaccine be given to me or to the person named above for whom I _____ am authorized to make this request.

Relation: Self____ Others, Specify: _____              Date: _____

Signature : _____ Print name: _____

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FOR INTERNAL USE ONLY: PRINT ALL INFORMATION BELOW

Moderna COVID-19 Vaccine: Lot:_____          Exp. Date if applicable: _____

Injection site:          LA          RA             1$^{st}$ dose____       2$^{nd}$ dose____

Immunizer's Name: _____  Immunizer's Signature_____

Date Administered:_____ Time of Administration: _____

## PLEASE PROVIDE INSURNACE INFORMATION FOR PERSON RECEIVING VACCINE

1. Do you have insurance?
   ☐   YES
   ☐   NO
2. Name of insurance Company: _____ Phone number: _____

   Card ID number ( Medicare Part B ): _____

   Group number:_____ BIN number: _____ PCN #: _____


3. Name of insurance Company: _____ Phone number: _____

   Card ID number (Private or secondary ): _____

   Group number : _____ BIN Number:_____ PCN # : _____

## COVID-19 VACCINE FORM

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COMPOUNDING
PHARMACY

# Information for Vaccine Recipients

For more information on the Moderna COVID-19 Vaccine:

Scan the QR code or to get the Fact Sheet for Recipients and Caregivers: www.modernatx.com/covid19vaccine-eua

To Enroll on V-safe:

V-safe is a web-based tool that uses text messaging and web surveys to provide personalized health check-ins after you receive a COVID-19 vaccination. Through v-safe, you can quickly tell CDC if you have any side effects after getting the COVID-19 vaccine. Depending on your answers, someone from CDC may call to check on you and get more information. And v-safe will remind you to get your second COVID-19 vaccine dose if you need one.

Your participation in CDC's v–safe makes a difference — it helps keep COVID-19 vaccines safe scan the QR code or go to vsafe.cdc.gov

Next Appointment Date:_____/_____/_____at_____:_____AM   PM
Please bring your ID and a new completed form to next appointment