

# VACCINE ADMINISTRATION



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone #: \_\_\_\_\_ Race: \_\_\_\_\_

Street: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ Sex: M / F

CHECK THE BOX OF THE VACCINE YOU WANT TO GET TODAY. DO NOT CHECK VACCINES YOU'VE HAD PREVIOUSLY.

Moderna 1st Dose  Pfizer 1st Dose  J&J 1st Dose  FLU SHOT   
 Moderna 2nd Dose  Pfizer 2nd Dose   
 Moderna Booster  Pfizer Booster

DO YOU MEET THE GUIDELINES FOR A COVID BOOSTER TODAY? YES  NO

A. Fever? Yes / No - Exposure? Yes / No - Symptoms? Yes / No	Yes	No	Don't Know
1. Please circle which arm you would like the vaccine administered LEFT ARM RIGHT ARM			
2. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you previously been diagnosed with Covid-19? If so, what date?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have allergies to medications, food, latex or vaccine component?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had Guillain Barre Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any long-term health problems with heart, kidney and/or lung disease, asthma, metabolic disease (e.g. diabetes, anemia or other blood disorder?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, other steroids, anti-cancer drugs, or have you had radiation treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you had a seizure or brain or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Women: Are you pregnant or is there a chance you could be pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever received a shingles vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you had a pneumonia vaccine within the past five years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Patient Consent for Vaccination Signature:** \_\_\_\_\_ Date: **10/7/22**

Please send confirmation of vaccination to Dr. Gigante. fax 843-681-4721

