

ADMIN NURSE: _____

Moderna
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Public Health
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COVID-19 VACCINATION SCREENING QUESTIONS

Instructions: Fill out the following questionnaire **as clearly as possible**. Fill out one form per one person.
Form must be completely filled out.

VACCINE DOSE: **FIRST** **SECOND** DATE: _____ CURRENT TIME: _____

FIRST NAME: _____ LAST NAME: _____

CELL PHONE: _____ EMAIL: _____

(Please initial): _____ I AM 18 YEARS OF AGE AND OLDER BIRTHDATE: _____
Under 18 years of age, parent must sign consent on question 9 below

SEX: M or F RACE: _____ ETHNICITY: _____

COUNTRY OF BIRTH: _____

ADDRESS: _____ ZIP CODE: _____

CITY: _____ STATE: _____ COUNTY: _____

JOB TITLE: _____

PLACE OF EMPLOYMENT: _____

CHECK ONE OF THE FOLLOWING ANSWERS

Yes No

1. Are you currently pregnant or breastfeeding?
2. Have you received convalescent plasma in the past 3 months?
3. Have you received monoclonal antibodies in the past 3 months?
4. Have you been diagnosed with COVID-19 in the past?

○ **When:**

5. 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?

6. Did you have a severe allergic reaction after receiving a COVID-19 Vaccine?

**I have not yet
received the
Vaccine**

7. Have you received any other vaccinations in the past 14 days?

8. Have you ever had a severe allergic reaction after receiving another vaccine or another injectable Medication

9. I (PLEASE SIGN) _____ authorize to consent for vaccination for the patient named above who is at least 12 years of age.

10. Vaccine Arm: _____ (LEFT OR RIGHT)