DUNCANSVILLE PHARMACY

1328 3rd Avenue Duncansville, PA 16635
814-695-8065

PLEASE PRINT CLEARLY

PATIENT INFORMATION

PATIENT NAME: (Last)	(First)	(MI)
GENDER: M / F / Self-Identify	**DATE OF BIRTH:** (MM/DD/YYYY)	
ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
CELL PHONE NUMBER:	**IF NO CELL, LANDLINE:**	**EMAIL:**

RACE: (Circle one) White Asian Black/African American Hispanic Other

Is this the patient's first or second dose of the COVID-19 vaccination? ☐ First Dose ☐ Second Dose

SCREENING QUESTIONS

	DOSE 1 Yes	DOSE 1 No	DOSE 2 Yes	DOSE 2 No
1. Are you feeling sick today?				
2. Have you received passive antibody therapy as a COVID-19 treatment? (If yes, date: ______________________)				
3. Have you received a dose of any COVID-19 vaccine, PRIOR to this series? (If yes, which one: ________________________)				
4. Do you have a bleeding disorder?				
5. Do you take prescription blood thinners?				
6. In the past 14 days, have you ever tested positive for COVID-19?				
7. Have you received another vaccine in the past 14 days?				
8. Have you ever had an allergic reaction to previous vaccines, other injectables, or shellfish? (If yes, please explain: _________________________)				
9. Do you have a weakened immune system or take immunosuppressive drugs? (If yes, please explain: ____)				
10. Are you pregnant or breastfeeding?				
11. In the past 10 days, have you experienced: fever, chills, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?				
12. I read the current (EUA) Vaccine Information Statement for the COVID-19 vaccine and understand the benefits and risks.				

My signature below authorizes Duncansville Pharmacy to vaccinate myself with the COVID-19 vaccine. I also agree to hold harmless Duncansville Pharmacy (all officers, agents, or employees) against claims, demands, actions, suits, damages, liabilities, losses, settlements, judgements, costs, and any expenses, which may arise out of or relate to the administration of this vaccine.

We ask that after administration of the vaccine, you wait approximately **15** minutes to monitor any reactions that may occur.

Signature **Dose 1**: ____ Date: _______________________

Signature **Dose 2**: ____ Date: _______________________

PHARMACY TO COMPLETE BELOW:

Dose 1	Arm: L or R	Date: ____/____/______	Moderna LOT:	Exp:
Dose 2	Arm: L or R	Date: ____/____/______	Moderna LOT:	Exp:

INSURANCE:

Insurer Name (i.e., UPMC, Humana, Blue Cross): ____

ID: ____

RX GROUP: ___________________________________

RX BIN: _______________________________________

RX PCN: ______________________________________

NO INSURANCE _______