

<b>BIVALENT COVID-19</b>	Cell Phone-		Reviewed by Nurse	
Last Name	First Name	MI	BIRTH DATE	AGE
Address			Doctor	
<b>MODERNA Vaccine 18 years and up</b>				
<b>PFIZER VACCINE 12 years and up</b>				

- Y - N 1. Do you feel sick or have a fever today?
- Y - N 2. Do you have any allergies? If yes, what \_\_\_\_\_
- Y - N 3. Do you have severe allergies that require you to carry an Epi-Pen?
- Y - N 4. Do you have a bleeding disorder or are on a blood thinner?
- Y - N 5. Have you had a positive COVID-19 test? When \_\_\_\_\_
- Y - N 6. Have you ever received passive antibody therapy as a treatment for COVID-19?
- Y - N 7. Have you received a vaccine in the last 4 weeks?
- Y - N 8. Have you ever had any problems after receiving an immunization?
9. When did you receive your last COVID-19 vaccine? \_\_\_\_\_ Pfizer or Moderna?
- FEMALE ONLY: Y - N** Are pregnant or plan to become pregnant or breastfeeding?

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## FOR OFFICE USE ONLY

Brown County Health Department 120 E Main Street Mt. Sterling, IL 62353

Date	Vaccine	MFG	Lot number	Route	Site	Check VAC Statement given	Initials of nurse
	BIVALENT MODERNA PFIZER			IM			
Route	Site	Initials	Signature of Nurse administering the vaccine				
IM- intramuscular	Rd- Right Deltoid Ld- Left Deltoid						