PLEASE CHECK ONE:
COVID #1 [ ], COVID #2 [ ], COVID #3 [ ], COVID Booster [ ], Flu shot [ ], Other [ ]

Please list the vaccine you are receiving today:_____

Vaccine Screening Form

Last Name: _____ First Name: _____ M.I: _____ DOB: _____/_____/_____

Phone Number: (_____) _____ - _____ Age: _____ Gender: Male Female

Street Address: _____ City: _____State: _____ Zip Code: _____

Email: _____ _____ Allergies: _____

Race: _____ Mothers Maiden Name: _____ Injection Arm: Left Right

Medications: _____

Please answer the following questions for any immunization:
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
Do you have allergies to medications, food, a vaccine component, or latex?	YES	NO	UNSURE
Have you ever had a serious reaction after receiving a vaccination?	YES	NO	UNSURE
Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (diabetes), asthma, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak?	YES	NO	UNSURE
Do you have a bleeding disorder or are you taking a blood thinner?	YES	NO	UNSURE
Do you or someone you live with have cancer, leukemia, HIV/AIDS, or any other immune system problem?	YES	NO	UNSURE
In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohns disease, or psoriasis; or have you had radiation treatment?	YES	NO	UNSURE
Have you had a seizure or a brain or other nervous system problem?	YES	NO	UNSURE
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	YES	NO	UNSURE
Have you received any vaccinations in the past 4 weeks	YES	NO	UNSURE
For women: Are you pregnant or is there a chance you could become pregnant during the next month?	YES	NO	UNSURE

If you are here for COVID-19 vaccine please answer the following questions:

Have you ever received a dose of COVID-19 vaccine?	YES	NO	UNSURE
If yes, which vaccine product? (circle) Pfizer BioNTech Moderna Johnson & Johnson/Janssen Another Product: _____			
Was the severe allergic reaction after receiving a COVID-19 vaccine?	YES	NO	UNSURE
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	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

Please turn over* *Please turn over* *Please turn over*

Buford Road Pharmacy
2608 Buford Road, Richmond, VA 23235
P: 804-272-1423

BUFORD ROAD PHARMACY

If you are here for a 3rd COVID-19 vaccine dose or booster COVID-19 vaccine dose, please answer the following questions:

If here for the COVID third dose for immunocompromised, Please answer questions below:			
Been receiving active cancer treatment for tumors or cancers of the blood	YES	NO	UNSURE
Received an organ transplant and are taking medicine to suppress the immune system	YES	NO	UNSURE
Received a stem cell transplant within the last two years or are taking medicine to suppress the immune system	YES	NO	UNSURE
Moderate or severe primary immunodeficiency (DiGeorge syndrome, Wiskott-Aldrich syndrome)	YES	NO	UNSURE
Advanced or untreated HIV infection	YES	NO	UNSURE
Active treatment with high-dose corticosteroids (≥20mg prednisone/day) or other drugs that may suppress your immune response	YES	NO	UNSURE
Have you received **BOTH** vaccine shots (either Moderna or Pfizer) at least 28 DAYS ago?	YES	NO	UNSURE
If here for the COVID Booster dose, Please answer the questions below			
Have you received BOTH Pfizer or Moderna Shots at least 5 MONTHS ago or the Janssen shot at least 2 MONTHS ago?	YES	NO	UNSURE
Do you have frequent or likely occupational/employment related COVID-19 exposure (such as healthcare or essential worker)?	YES	NO	UNSURE
Are you ≥65 years old?	YES	NO	UNSURE
Are you ≥18 years old and have a health condition that puts you at high risk of severe COVID-19?	YES	NO	UNSURE

I agree to wait inside Buford Road Pharmacy for at least 15 minutes to be monitored for vaccine adverse reactions. I have also had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the vaccine. I certify that I am at least 18 years old, or a legal guardian of a <18 year old, and hereby give my consent to the staff at Buford Road Pharmacy to administer the vaccine(s) to the patient listed above. I understand that this vaccine will be reported to the Virginia Immunization Information System.

_____ _____/_____/_____

Signature Date

"I request that payment of authorized **Medicare benefits (i.e. for Pneumonia and/or Flu vaccine**) be made to me or on my behalf to Buford Road Pharmacy for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services"

_____ _____/_____/_____

Signature Date

For Internal Use Only:

Date	Vaccine Name and Manufacturer	Lot # and Exp. Date	Dose and Site	Administered by and Title	VIS Date
			_____ mL L or R Deltoid or arm IM or SQ		
			_____ mL L or R Deltoid or arm IM or SQ		
			_____ mL L or R Deltoid or arm IM or SQ		