BI·MART
Your Pharmacy of Choice

COVID-19 Screening Questionnaire (v2021)

Print Your Name (As it appears on Insurance Card): ____

Date of Birth: _____/_____/_______ **Home Phone:** ___________________________________

Email: __________________________ **Cell Phone:** _____________________________________

1. Do you currently have, or have you had, two (2) or more of the symptoms listed below in the last 72 hours that you cannot attribute to another health condition?

- Cough
- Fatigue
- Chills
- Muscle or body aches
- Sore throat
- Nausea or vomiting
- Shortness of breath or Difficulty breathing
- Fever (100.4 degrees or higher)
- Congestion or runny nose
- Headache
- New loss of taste or smell
- Diarrhea

☐ YES ☐ NO

2. Within the last 14 days, have you had close contact with someone who is currently sick with suspected or confirmed COVID-19? (Close contact is defined as within 6 ft. for more than 15 minutes).

☐ YES ☐ NO

I affirm and certify that my answers above are complete, true and correct to the best of my knowledge and belief. I also hereby attest under the penalties of perjury to the best of my knowledge and belief that I meet the current State or County eligibility requirements for receiving the COVID -19 vaccine.

Patient/Guardian Signature: ______________________________ **Date:** ____/____/______

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COVID-19 VACCINE ADMINISTRATION RECORD (vC2021c)

Please provide a copy of your insurance card if available.

Print Your Name (As it appears on Insurance Card): ______________________________

Date of Birth: _____/_____/________ **Age:**_______ **Gender:** ☐ **Male** / ☐**Female**

Home Street Address: ______________________________

City, State & Zip: ______________________________ **Home Phone:** ____________________

Race: (check all that apply) ☐ African American ☐ American Indian/Alaskan Native ☐ Asian
☐ Native Hawaiian/ Pacific Islander ☐ White ☐ Decline to answer

Ethnicity: Hispanic? ☐ Yes ☐ No ☐ Decline to answer Primary **Language:** ____________________

Vaccination requested (no data on co-administering vaccines): ***COVID-19*** Moderna, Pfizer, J&J ☐

(Please check responses and provide details below)

Question	Yes	No
Do you currently feel ill or have a fever?________	☐Yes	☐No
Have you received a dose of COVID-19 vaccine________ Which one? ☐ Pfizer ☐ Moderna ☐ J&J ☐ Other	☐Yes	☐No
Have you ever had a severe allergic reaction to something? ________	☐Yes	☐No
Have you had a severe reaction to a previous vaccination or injectable drug, including COVID 19?________	☐Yes	☐No
Have you received another vaccine in the last 14 days? ________	☐Yes	☐No
Have you had a positive test for COVID-19 or has a doctor ever told you that you have COVID-19?________	☐Yes	☐No
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID -19?________	☐Yes	☐No
Do you or anyone you are in contact with have immune suppression caused by any drugs or therapies and/or diseases such as cancer or HIV? ________	☐Yes	☐No
For women: Are you pregnant, planning to become pregnant soon, or breast-feeding?________	☐Yes	☐No
Are you currently being treated for any chronic diseases such as heart, lung, or kidney disease, asthma, seizures, diabetes, or blood disorder (anemia)?________	☐Yes	☐No
Have you received any vaccinations in the past 4 weeks? ________	☐Yes	☐No

I would prefer to be vaccinated in my: ☐ Left arm ☐ Right arm

Vaccine administration consent: **I have received the EAU Fact sheet for recipients and have read or have had explained to me the information in that sheet. I have had a chance to ask questions and they were answered to my satisfaction. I recognize and understand that there are benefits and risks associated with any vaccine. I acknowledge that by giving consent, my participation is solely at my own risk, and that I assume full responsibility for any resulting injuries and damages.**

I do, for myself, (and for the recipient of the vaccine if the recipient is a minor), my heirs, executors and assigns, hereby waive, release, and forever discharge Bi-Mart Corporation, its officers, directors, agents and employees, from and against any and all claims, demands, actions or causes of action for damages or personal injury, or death, arising out of or in connection with the quality of the above described vaccine, and any claims for negligence in connection with the related injection of the vaccine.

I understand that some or all of the information on this vaccination record is required by law to be reported to an immunization registry. I request and authorize the pharmacist to administer the vaccine to me.

Patient/Guardian Signature: ______________________________ **Date:** ___/___/_____

Vaccination #1

Place Pharmacy Prescription Label Here

For injectable vaccines the Sig must contain:

INJECT [*0.xxML*] [*IM*] **INTO THE** [*RIGHT* or *LEFT*] [*DELTOID*] **BY** [PHARMACIST'S NAME/TECH NAME, TITLE], **VACCINE LOT #** XXXXX, **EXP DATE** XX/XX/XX, **EAU FACT SHEET VERSION DATE** XX/XX/XX

(FOR PHARMACY USE)

Clinic notes: (Patient Risk Group, dose in series etc.)

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____
____
____
____

Registry Checked (if required) ☐

____
Pharmacist Signature - Substitution Permitted

____
Pharmacist Signature - Dispense as Written