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Patient Intake Form for the COVID-19 Vaccination

Please carefully read and complete this form.

First Name	
Date of Birth	
Today`s Date	

Last Name	
6-Digit VacMe Code	

Please indicate which dose you are receiving: ☐ 1st dose ☐ 2nd dose

Potential Contraindications

Do you currently have a fever or cold symptoms (sore throat, cough, body aches, headache, loss of taste or smell)? ☐ YES ☐ NO

If yes, then please be tested for COVID-19 and book an appointment to receive your vaccine at a later date.

Were you diagnosed with COVID-19 in the past? ☐ YES ☐ NO

Do you have any allergies (such as to medications or to previous vaccinations or food)? ☐ YES ☐ NO

If so, which one? _____

Have you had a problem with a previous vaccination? ☐ YES ☐ NO

If so, which one? _____

Are you taking anticoagulants ("blood thinners") or do you have a medical condition that makes you more likely to bleed? ☐ YES ☐ NO

If so, which one? _____

Are you currently pregnant or is there a possibility that you might be pregnant? ☐ YES ☐ NO