2021 COVID SCREENING

New England Pediatrics

DATE ____/____/____

PATIENT/CLIENT NAME

_____ _____

LAST FIRST

1.) In the past 24 hours, has the patient had a fever greater than 100.4 F, or had chills, sweats, or cough?

Yes _____ No _____

2.) Within the past 10 days is patient or a household member a close contact of someone who has tested positive for COVID-19?

Yes _____ No _____

If you answer "yes" to these questions, you must re-schedule your flu vaccine appointment.

2021 FLU VACCINE ADMIN RECORD

Date of Birth: ____/____/____ Age: _____

Is the patient well, including no fever, no cough? Yes _____ No _____

Is the patient allergic to eggs? Yes _____ No _____

Has the patient had a flu shot in the past? Yes _____ No _____

For Ages 12 and up: Have you received COVID Vaccine? Yes _____ No _____

TYPE _____ DATE ____/____/____ DATE ____/____/____
Pfizer, Moderna, J&J Dose #1 Dose #2

Above information completed by: _____

Relationship to patient: _____

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