I would like to receive the following Immunization(s):

□ Covid-19 FIRST DOSE   □ Covid-19 SECOND DOSE

ALL VACCINES

1. Are you sick today (fever, vomiting, diarrhea)?
   □ Yes   □ No   □ I don't know

2. Have you ever received a dose of Covid-19 vaccine? If yes, which vaccine product?
   □ Yes   □ No   □ I don't know
   □ Pfizer   □ Moderna   □ Johnson and Johnson

3. Do you have any allergies to medication, food, vaccines, or latex?
   □ Yes   □ No   □ I don't know

4. Have you ever had a serious reaction after receiving a vaccination?
   ● Was the severe allergic reaction after receiving another vaccine or another injectable medication?
   □ Yes   □ No   □ I don't know
   ● Was the severe allergic reaction after receiving a COVID-19 vaccine?
   □ Yes   □ No   □ I don't know
   ● Was the severe allergic reaction related to receiving Polyethylene Glycol or products containing Polyethylene Glycol?
   □ Yes   □ No   □ I don't know
   ● Was the severe allergic reaction related to receiving Polysorbate or products containing Polysorbate?
   □ Yes   □ No   □ I don't know

5. Do you have a long-term health problem like heart disease, lung disease, asthma, kidney disease, diabetes, anemia, or other blood disorder?
   □ Yes   □ No   □ I don't know

6. Do you have a seizure disorder, brain disorder, or nervous system problem?
   □ Yes   □ No   □ I don't know

7. Have you received any vaccines in the past 14 days?
   □ Yes   □ No   □ I don't know

8. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?
   □ Yes   □ No   □ I don't know

9. Do you have a bleeding disorder or are you taking a blood thinner?
   □ Yes   □ No   □ I don't know

10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?
    □ Yes   □ No   □ I don't know

I have been offered a copy of the "Vaccine Information Statement(s)" checked below. I have read, have had explained to me and understand, the information in the "Vaccine Information Statement(s)". I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am the parent or guardian or am otherwise authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself and on behalf of the person named below.

***Signature***: ______________________________________________________ Date:___________________________

<table>
<thead>
<tr>
<th>Vaccine (Manufacturer)</th>
<th>Dosage</th>
<th>Site</th>
<th>NDC</th>
<th>Lot#</th>
<th>Expiration</th>
<th>VIS date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODERNA Covid-19 Vaccine</td>
<td>IM</td>
<td>0.5mL</td>
<td>L / R</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PFIZER Covid-19 Vaccine</td>
<td>IM</td>
<td>0.3mL</td>
<td>L / R</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JOHNSON AND JOHNSON Covid-19 Vaccine</td>
<td>IM</td>
<td>0.5mL</td>
<td>L / R</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Immunizer name:_______________________________   Immunizer signature:______________________________

Intern name (if applicable): ___________________   Administration date:____________________________