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:___________________________