COVID-19 Vaccine Administration Record

Section 1: Vaccine Recipient Information

Name: _____ Date of Birth: _____

Phone Number: _____ Gender: ☐ Male ☐ Female

Address: _____
Street

_____ _____ _____
City State Zip

Allergies: ☐No Known Allergies ☐Eggs ☐Latex ☐Other: _____

Medical Conditions: _____

_____

Race

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ White
☐ Native Hawaiian
☐ Other Race
☐ Other Pacific Islander

Ethnicity

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Primary Language

☐ English ☐ Spanish ☐ Other: _____

Primary Healthcare Provider: _____

Section 2: Screening for Vaccine Eligibility

How many doses of the COVID-19 Vaccine have you received in the past? _____ doses

Brand of last COVID-19 Vaccine: ☐ Pfizer ☐ Moderna ☐ J&J ☐Other: _____

- Date of your last COVID-19 Vaccine: _____ / _____ / _____

Section 3: Insurance

Do you have insurance? ☐ Yes ☐ No

If yes, please provide insurance information for the vaccine recipient. For Medicare, please present your red, white, and blue Medicare card to the pharmacy staff.

BIN: _____ PCN: _____ Group: _____ ID: _____

Section 4: Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or licensed vaccine. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Section 5: Consent

I have read or have had explained to me the information provided in the Emergency Use Authorization (EUA) Factsheet or Vaccine Information Statement about the COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand that the provider is required to report all COVID vaccine doses to the state Immunization Information System. I understand the benefits and risks of the COVID-19 vaccine and ask that the vaccine be administered to me or to the person named above for whom I am authorized to make this request. The scope of this consent includes administration of the vaccine, discussion with a provider if requested, care, and treatments immediately after administration as needed.

Signature: _____ Date: _____

Healthcare Provider Use Only

Date Administered: _____ Injection Site (IM, Deltoid): ☐ Left ☐ Right Dose: _____ mL

Vaccine Manufacturer: ☐ Pfizer ☐ Moderna ☐ J&J ☐ Other: _____ Dose #: _____

Lot: _____ Exp: _____ Diluent Lot: _____ Diluent Exp: _____

_____
Vaccine Administrator Name

_____ _____
Substitution permitted Dispense as written

EUA Factsheet provided on: ☐ Date of Vaccine Administration ☐ Other date: _____

Published date of EUA Factsheet: _____

Vaccination Screening Form

_____ _____/_____/_____

First Name M.I. Last Name Date of Birth (MM/DD/YYYY)

Screening Questionnaire	Yes	No	Unknown
Are you feeling sick today?			
Have you been treated with antibody therapy for COVID-19 in the past 90 days			
Have you had a serious or life-threatening allergic reaction, such as hives or difficulty breathing to *any* vaccine or shot?			
Have you had any vaccines in the past 14 days?			
Are you pregnant, considering becoming pregnant, or breast feeding?			
Do you have cancer, leukemia, HIV/AIDS, history of autoimmune disease or any other condition that weakens the immune system?			
Do you take any medications that affect your immune system such as steroids, anticancer drugs, or have you had any radiation treatments?			
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
Have you had a seizure or a brain or other nervous system problem?			
Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g, diabetes), anemia, or other blood disorder?			

Patient Health Assessment

Within the past 14 days, have you experienced any of the following symptoms? (Check Yes or No)

Sign/Symptom	Yes	No	If Yes, is this a New or Chronic Symptom
Fever or chills			
Cough			
Shortness of breath or difficulty breathing			
Fatigue			
Muscle or body aches			
Headache			
New loss of taste or smell			
Sore throat			
Congestion or runny nose			
Nausea or vomiting			
Diarrhea			

Patient: I have read or have had explained to me the information provided in the Emergency Use Authorization (EUA) Factsheet or Vaccine Information Statement (VIS) about the vaccine(s) I am requesting today. I have had the chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits/risks of the vaccine(s) and ask that it is given to me or the person named above for whom I am authorized to make this request.

_____ _____

Patient Signature Date

COVID-19 Vaccine Minor Consent Form

Parent or legal guardian consent is required for a patient under the age of 18 to receive a COVID-19 vaccine at our pharmacy. Please call the pharmacy to ensure there is stock available of the vaccine for a patient under the age of 18.

Requirements by age group:

- Patients 5-15 years old must have a parent or legal guardian present at the vaccine appointment. This COVID-19 Vaccine Minor Consent Form must be completed by a parent or legal guardian.
- Patients 16-17 years old need to bring this COVID-19 Vaccine Minor Consent Form completed by a parent or legal guardian to the vaccine appointment. The parent or legal guardian does not need to be present at the vaccine appointment.

_____	_____	_____	_____
Patient Name	Date of Birth	Age (in years)	Weight (in lbs)

Information on the risks and benefits of the Pfizer COVID-19 Vaccine

The Pfizer-BioNTech (Pfizer) COVID-19 Vaccine "Fact Sheet for Recipients and Caregivers" is available at https://www.fda.gov/media/144414/download.

I have reviewed the information on risks and benefits of the Pfizer COVID-19 Vaccine above and understand the risks and benefits. In providing my consent below, I agree that:

1. I have reviewed this consent form, and I understand that the "Fact Sheet for Recipients and Caregivers," includes more detailed information about the potential risks and benefits of the Pfizer COVID-19 Vaccine.
2. I have the legal authority to consent on behalf of the child/minor named above to vaccination with the Pfizer COVID-19 Vaccine.
3. I understand I may not be required to accompany the child/minor named above to their vaccination appointment and that, by giving my consent below, the child/minor may receive the Pfizer COVID-19 Vaccine whether or not I am present at the vaccination appointment.

I GIVE CONSENT for the child/minor named on this form to get vaccinated with the two-dose Pfizer COVID-19 Vaccine and have reviewed and agree to the information included in this form. The scope of this consent includes administration of the vaccine, discussion with a provider if requested, care and treatments immediately after administration as needed. If this consent is not signed, dated, and returned, the child/minor will not be vaccinated.

_____	_____
Name of Parent or Legal Guardian	Relationship to patient
_____	_____
Signature of Parent of Legal Guardian	Date