



COVID-19 Vaccine Immunization Administration Record

*Pharmacy Reminder: Copy ID, Medicare B Card, Medical Ins Card, and RX Ins Card

First Name:	Last Name:	Sex assigned at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Address:	City:	State:	Zip:	
Phone:	Social Security Number:			
Population/Occupation:	Birthdate:	Age:	Weight(Lb):	
Race: <input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American		
<input type="checkbox"/> Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Unknown/Not Reported		
Ethnicity: <input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Unknown/Not Reported		
Primary Care Physician (PCP) First Name:		PCP Last Name:		
PCP Address:				
PCP Phone:		PCP Fax:		

Indications: Please check "yes" or "no" for each question.		Yes	No	Notes
1.	Are you 18 years of age or older? <i>Please note: The CDC prefers Moderna or Pfizer COVID-19 vaccine. There is a rare risk of blood clots with low platelets following Janssen COVID-19 vaccination. Males aged 12-29 years: please note the rare risk of myocarditis/pericarditis after mRNA vaccination. Patients 5-17 years: may receive Pfizer vaccine only.</i>			Age:
2a.	Have you previously received a dose of COVID vaccine? What product? When? Product: _____ Date(s) received: _____			
2b.	Please choose one of the following that best describes you, if applicable: OR I attest that I have a weakened immune system and meet the current requirements of the Centers for Disease Control and Prevention (CDC) for a third dose of Pfizer or Moderna COVID-19 vaccine.			OR
2c.	I attest that I meet the current requirements of the Centers for Disease Control and Prevention (CDC) for a booster dose of Pfizer, Moderna, or Janssen COVID-19 vaccine.			
Precautions and Contraindications: Please check "yes" or "no" for each question.		Yes	No	
3.	Are you feeling sick today?			
4.	In the past 10 days, have you been in contact with someone who has confirmed or suspected COVID-19?			
5.	In the past 10 days, have you had any of the following symptoms: cough, fever, loss of smell or taste, shortness of breath, chills, fatigue, muscle or body aches, headache, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?			
6.	In the past 10 days, have you had a positive test or doctor's diagnosis for COVID-19?			
7.	In the past 90 days, have you received plasma or monoclonal antibodies for COVID-19?			
8.	In the past 90 days, have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?			
9.	Have you ever had an allergic reaction to a COVID-19 vaccine component (Polyethylene glycol or PEG; POLYSORBATE), or to a previous dose of a COVID-19 vaccine?			
10.	Have you ever had an allergic reaction to another vaccine (other than COVID-19); an injectable medication; or something else, such as food, pet, venom, environment or oral medications?			
11.	Do you have a history of thrombosis with thrombocytopenia syndrome (TTS) following vaccination with Janssen COVID-19 vaccine, a history of heparin-induced thrombocytopenia (HIT), a bleeding disorder, or are you taking a blood thinner?			
12.	Do you have a history of myocarditis or pericarditis?			
13.	Do you have a weakened immune system or are you taking medication that affects your immune system?			
14.	Do you have a history of Guillain-Barré Syndrome (GBS)?			
15.	Do you have dermal fillers?			
16.	For women: Are you pregnant or nursing?			

Consent for services, medical records, and HIPAA privacy information

Medicare/Medigap Policy Holders: I request and assign payment of authorized Medicare and/or Medigap benefits, as applicable, to be made on my behalf to Giant Eagle Pharmacy for any products or services furnished by them to me. I authorize the release of medical information about me to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents as necessary to determine benefits payable for these or related services.

All Patients: I acknowledge receipt of Giant Eagle's Notice of Privacy Practices and authorize the release of immunization information to Federal and state authorities and to any covering health insurance provider(s). For the vaccine(s) indicated hereon, I acknowledge receipt of the relevant Vaccine Information Sheet (VIS) or EUA Fact Sheet. I affirm that I have had the opportunity to ask questions and that I voluntarily assume full responsibility for any reactions that may result. I request administration of the immunization(s) to me or to the patient identified hereon for whom I am the legal guardian. I, for myself, my wards, heirs, executors, personal representatives and assigns, hereby release Giant Eagle, Inc., the hosting facility and its managing and operating companies and owners, the event sponsors, and each entity's respective affiliates, subsidiaries, divisions, directors, contractors, agents and employees, from any and all claims arising out of, in connection with, or in any way related to, the receipt or administration of the immunization(s) indicated hereon. Further, I affirm that I request and access these services at my own risk and will not hold the aforementioned parties, to any extent whatsoever, liable, responsible, or in any way accountable for any loss, physical or personal injury, death, or damages suffered or sustained at any time in connection with or as a result of their offering of this vaccine program, the administration or receipt of the vaccines requested, or access to or use of the hosting facilities.

Signature (Patient or Parent/Legal Guardian): _____ Date: _____

Print Full Legal Name (Patient or Parent/Legal Guardian): _____

For School Clinics Only: My signature above indicates that I understand that if this release is executed in support of a school-sponsored immunization program, I consent to the person named above, for whom I am a parent or legal guardian, receiving the applicable immunization without me being present on the clinic date of: _____.

Giant Eagle Pharmacy Use Only

Patient Name: _____	DOB: _____
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By signing below, I agree that as the immunizing healthcare professional:

- I reviewed the patient's information and screening question responses.
- This vaccine is appropriate for this patient based on the responses to the screening questions and age guidelines according to ACIP recommendations, Giant Eagle's current vaccine protocols, and state or federal regulations.
- Appropriate written education has been provided to the patient, including a Well Child Visit Reminder as applicable.

Signature (Immunizer): _____ Date: _____

Print Name (Immunizer): _____ Title (Immunizer): _____

If Pharmacy Intern, overseeing Pharmacist to sign and print name: _____

If using PREP Act, Ordering Pharmacist signature: _____

Ordering Pharmacist NPI: _____ Ordering Pharmacist License #: _____

Patients 5 - 11 YEARS OF AGE and receiving DOSE 1, DOSE 2 or DOSE 3 for Immunocompromised Patients			
<input type="checkbox"/> Pfizer Peds BioNTech COVID-19 Vaccine (orange) (10 mcg/0.2 mL) Verify NDC: 59267-1055-01 RPH Initials: _____	<input type="checkbox"/> Dose 1 (SCC 2) (21 days apart)	<input type="checkbox"/> Dose 2 (SCC 6) (28 days apart)	<input type="checkbox"/> Dose 3 (SCC 7) (28 days apart)
Verify dose & volume: (10 mcg/0.2 mL) RPH Initials: _____	Lot Number: _____		Expiration Date: _____
Sig: Administer 1 shot intramuscularly into the: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid			Ordering Provider: _____
No Refills			

Patients 12 - 17 YEARS OF AGE and receiving DOSE 1, DOSE 2 or DOSE 3 for Immunocompromised Patients			
<input type="checkbox"/> Pfizer BioNTech COVID-19 Vaccine (purple/gray) (30 mcg / 0.3 mL) Verify NDC: 59267-1000-01; 59267-1025-01 RPH Initials: _____	<input type="checkbox"/> Dose 1 (SCC 2) (21 days apart)	<input type="checkbox"/> Dose 2 (SCC 6) (28 days apart)	<input type="checkbox"/> Dose 3 (SCC 7) (28 days apart)
Verify dose & volume: (30 mcg / 0.3 mL) RPH Initials: _____	Lot Number: _____		Expiration Date: _____
Sig: Administer 1 shot intramuscularly into the: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid			Ordering Provider: _____
No Refills			

Patients 18+ YEARS OF AGE and receiving DOSE 1 or DOSE 2			
<input type="checkbox"/> Pfizer BioNTech COVID-19 Vaccine (purple/gray) (30 mcg / 0.3 mL) Verify NDC: 59267-1000-01; 59267-1025-01 RPH Initials: _____	<input type="checkbox"/> Dose 1 (SCC 2) (21 days apart)	<input type="checkbox"/> Dose 2 (SCC 6) (28 days apart)	Lot Number: _____
<input type="checkbox"/> Moderna COVID-19 Vaccine (100 mcg / 0.5 mL) Verify NDC: 80777-273-10; 80777-273-15 RPH Initials: _____	<input type="checkbox"/> Dose 1 (SCC 2) (28 days apart)	<input type="checkbox"/> Dose 2 (SCC 6) (28 days apart)	Expiration Date: _____
<input type="checkbox"/> Janssen COVID-19 Vaccine (5X10 ¹⁰ viral particles / 0.5 mL) Verify NDC: 59676-0580-05 RPH Initials: _____	Dose 1 (SCC 2)		Ordering Provider: _____
Sig: Administer 1 shot intramuscularly into the: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid			No Refills

Patients 18+ YEARS OF AGE who are IMMUNOCOMPROMISED and receiving a THIRD DOSE			
<input type="checkbox"/> Pfizer BioNTech COVID-19 Vaccine (purple/gray) (30 mcg / 0.3 mL) Verify NDC: 59267-1000-01; 59267-1025-01 RPH Initials: _____	Dose 3 (SCC 7) (28 days after Dose 2)		Lot Number: _____
<input type="checkbox"/> Moderna COVID-19 Vaccine (100 mcg / 0.5 mL) Verify NDC: 80777-273-10; 80777-273-15 RPH Initials: _____	Dose 3 (SCC 7) (28 days after Dose 2)		Expiration Date: _____
Sig: Administer 1 shot intramuscularly into the: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid			Ordering Provider: _____
No Refills			

Patients receiving a BOOSTER DOSE
If Pfizer initial series, booster at 5 months. If Moderna initial series, booster at 5 months. If Janssen initial series, booster at 2 months.

Patients 12+ YEARS OF AGE receiving a BOOSTER DOSE			
<input type="checkbox"/> Pfizer BioNTech COVID-19 Vaccine (purple/gray) (30 mcg / 0.3 mL) Verify NDC: 59267-1000-01; 59267-1025-01 RPH Initials: _____	Booster Dose/3 (SCC 10)		Lot Number: _____
Patients 18+ YEARS OF AGE receiving a BOOSTER DOSE			
<input type="checkbox"/> Moderna COVID-19 Vaccine (50 mcg / 0.25 mL) Verify NDC: 80777-273-10; 80777-273-15 RPH Initials: _____	Booster Dose/3 (SCC 10)		Expiration Date: _____
<input type="checkbox"/> Janssen COVID-19 Vaccine (5X10 ¹⁰ viral particles / 0.5 mL) Verify NDC: 59676-0580-05 RPH Initials: _____	Booster Dose/3 (SCC 10)		Ordering Provider: _____
Sig: Administer 1 shot intramuscularly into the: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid			No Refills