Vaccine Administration Record and Consent

Name (First, MI, Last):_____
Address (City, State, and Zip): _____
Phone#: (_____)_____-_____ **DOB**: _____/_____/_____**Gender:** M / F
E-mail: _____

Race (Circle one): White l Black/African American l Asian l Native Hawaiian/Pacific Islander l Native Alaskan/American Indian l Other

Ethnicity (Circle one): Not Hispanic/Latino l Hispanic/Latino

Comorbidities (Circle all that apply): Asthma l Serious Heart Condition l Liver Disease l Chronic Lung Disease l Chronic Kidney Disease

Diabetes l Severe Obesity l Immunocompromised l None

Allergies (drugs, food, vaccines)**/Health conditions** (including pregnancy) _____
Insurance information: Medicare # (if applicable)_____
Rx BIN:_____ **Rx PCN**:_____
Rx Group: _____ **Member ID**:_____

Uninsured: _____ I do not have any health insurance, private insurance or government funded health benefit plan. Please provide one of the following options to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients.

Circle 1: Social Security Number **or** State ID Number & State **or** Driver's License Number & State

_____

Emergency Contact Name:_____

Emergency Contact Phone:_____ **Relationship to Patient:**_____

Health Questionnaire:

Please place an X on the line to help determine if the vaccine(s) may be given today. If you answer yes, please explain.

____Yes ____No 1. Do you feel sick today? (mild illnesses like upper respiratory infections or diarrhea are okay)
____Yes ____No 2. Have you received a dose of Covid-19 vaccine? If yes, which one? Moderna l Pfizer l Other _____
____Yes ____No 3. Have you ever had a severe reaction to a vaccine?
____Yes ____No 4. Have you ever had a severe allergic reaction after receiving a Covid-19 vaccine?
____Yes ____No 5. Have you ever had a severe allergic reaction after receiving another vaccine or injectable medication?
____Yes ____No 6. Was the severe allergic reaction related to receiving or products containing polyethylene glycol?
____Yes ____No 7. Was the severe allergic reaction related to receiving or products containing polysorbate?
____Yes ____No 8. Have you received any vaccine within the past 14 days?
____Yes ____No 9. Have you received monoclonal antibodies or convalescent plasma as part of a Covid-19 treatment in the past 90 days?
____Yes ____No 10. Do you have a bleeding disorder or are you taking a blood thinner?
____Yes ____No 11. For women, are you currently pregnant or breastfeeding?
____Yes ____No 12. Do you have a weakened immune system caused by something like HIV or cancer or on immunosuppressive therapy?
____Yes ____No 13. Have you ever had a positive test for Covid-19 or has a doctor ever told you that you had Covid-19?
____Yes ____No 14. Have you experienced fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion, runny nose, nausea, vomiting, or diarrhea?

I understand the benefits and risks of the vaccination as described in the Fact Sheet for Recipients and Caregivers Emergency Use Authorization (EUA)/ Vaccination Information Statement (VIS), a copy of which was provided with this Consent and Release. I have received a copy of the notice of Privacy Practices and understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the Pharmacy and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information. I understand and acknowledge the administration of this vaccine will be entered into the ShowMeVax system administered by the Missouri Department of Health and Senior Services. I request that the vaccine be given to me or to the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release. I consent to the sharing and reporting of this vaccine information.

Signature: _____ **Date:** _____
Guardian name (print) if recipient is a minor:_____
Guardian phone number if recipient is a minor:_____

Covid-19 Vaccine
 # 1 dose
Inject into deltoid by pharmacist as directed by standing order.
Refills: 1 - DUR: PH, MA, 3N, 11

Dr. George Turabelidze
Substitution Permitted **Substitution Not Permitted**

For Pharmacy use only:

Vaccine	Lot #	Exp. Date	Manufacturer	Qty (mL)	Injection Site/Route	Date Administered	Date on EUA
COVID-19			Pfizer	0.3	IM Deltoid Left Right		5-10-2021

Vaccine Administered by: Emily McDonald l Madonna Mcfarland l Abigail Overby l Merry Lynn Schmittgens l Jason Wang l Other: _____

Location:_____Valley Park Schools_____