COVID-19 Vaccine Immunization Administration Record

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

First Name:	Last Name:		□ M □ F
Address:	City:	State:	Zip:
Phone:	Social Security Number:		
Population/Occupation:	Birthdate:	Age:	Weight(Lb):
Race: □ American Indian or Alaska Native	□ Asian		□ Black or African American
□ Hawaiian or Other Pacific Islander	□ White		□ Unknown/Not Reported
Ethnicity: □ Hispanic or Latino	□ Not Hispanic or Latino		□ Unknown/Not Reported
Primary Care Physician (PCP) First Name:	PCP Last Name:		
PCP Address:			
PCP Phone:	PCP Fax:		
Medicare B Insurance Name as it appears on your card:		ID#:	
Medical Insurance:	Group#:	ID#:	
Prescription Insurance:	Group#:	ID#:	

	Indications: *Please check "yes" or "no" for each question.*	**Yes**	**No**	**Notes**
1.	Are you 18 years of age or older? *Women aged 18-49 years: please note the rare risk of blood clots with low platelets following vaccination with **Janssen COVID-19 vaccine.*** *Patients 12-17 years of age are only eligible to receive **Pfizer COVID-19 vaccine**.*			Age:
2.	Have you previously received a dose of COVID vaccine? What product? When? Product: Date received:			
	Precautions and Contraindications: *Please check "yes" or "no" for each question.*	**Yes**	**No**	
3.	Are you sick today? *Record patient temperature*			Temp:
4.	In the past 14 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 14 days, have you received any vaccinations?			
9.	Do you have allergies to food, medications, a vaccine component (PEG, POLYSORBATE), or latex?			
10.	Have you ever had a severe allergic reaction to something?			
11.	Do you have a bleeding disorder or are you taking a blood thinner?			
12.	Do you have a weakened immune system or are you taking medication that affects your immune system?			
13.	Do you have dermal fillers?			
14.	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 Legal Guardian): _____Date:_____

Print Full Legal Name: _____

Reviewed: 5/12/21 CG

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Giant Eagle Pharmacy Use Only

Patient Name:	DOB:

□ Verbally confirmed patient meets the eligibility requirements for the current phase of vaccination.

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 regulations.

Signature (Immunizer):_____ Date:_____

Print Name (Immunizer):_____Title (Immunizer):_____

If Pharmacy Intern, print name of overseeing Pharmacist: _____

Vaccine: □ Pfizer BioNTech COVID-19 Vaccine (0.3 mL) IM Dose:_____	**Lot Number:**
□ Moderna COVID-19 Vaccine (0.5 mL) IM Dose:_____	**Expiration Date:**
□ Janssen COVID-19 Vaccine (0.5 mL) IM	**Ordering Provider:**
Sig: Administer 1 shot intramuscularly into the: □ Left Deltoid □ Right Deltoid	**No Refills**

Screening Questions Reference

Question	Response	Guidance **Depending on state specific guidelines**
1.	Yes/No	**Pfizer Vaccine:** Administer to patients desiring immunity to SARS-CoV-2 who are 12+ years of age. **Moderna and Janssen Vaccines:** Administer to patients desiring immunity to SARS-CoV-2 who are 18+ years of age. Counsel women younger than 50 years old on the rare risk of blood clots with low platelets following vaccination with **Janssen COVID-19 vaccine** and the availability of other COVID-19 vaccines where this risk has not been observed.
2.	Yes	**Pfizer Vaccine** should be administered as a 2-dose series at least 21 days apart. **Moderna Vaccine** should be administered as a 2-dose series at least 28 days apart. **Janssen Vaccine** is administered as a single dose. Vaccines are NOT interchangeable.
3.	Yes	As a precaution with moderate or severe acute illness, all vaccines should be deferred until the illness has improved. Mild illnesses (upper respiratory infections or diarrhea) are NOT contraindications to vaccination. Do not defer vaccination if a person is taking antibiotics. Measure the patient's temperature to screen for fever (defined as ≥100.0 ^{o}F per CDC guidance). Evaluate any reported symptoms that may be due to SARS-CoV-2 infection. Vaccination of persons with current SARS-CoV-2 infection should be deferred until the person has recovered from acute illness and they can discontinue isolation.
4.	Yes	Defer vaccination until it has been determined that the patient no longer poses a coronavirus transmission risk.
5.	Yes	Defer vaccination until the patient has been symptom free for at least 10 days.
6.	Yes	Vaccination of persons with current SARS-CoV-2 infection should be deferred until the person has recovered from acute illness and they can discontinue isolation. Vaccination should be offered to persons regardless of history of prior SARS-CoV-2 infection. While there is no recommended minimum interval between infection and vaccination, current evidence suggests that the risk of SARS-CoV-2 reinfection is low in the months after initial infection but may increase with time.
7.	Yes	Vaccination should be deferred for at least 90 days, as a precautionary measure until additional information becomes available, to avoid interference of the antibody treatment with vaccine-induced immune responses.
8.	Yes	Observe a minimum interval of 14 days before or after administration with other vaccines.
9.	Yes	**Pfizer and Moderna Vaccines:** DO NOT administer the vaccine to patients with a severe allergic reaction or immediate allergic reaction of any severity to a previous dose of the vaccine, or to any component of the vaccine, including **PEG**. **Janssen Vaccine:** DO NOT administer the vaccine to patients with a severe allergic reaction or immediate allergic reaction of any severity to any component of the vaccine, including **POLYSORBATE**. Check supplies if patient has a **LATEX** allergy.
10.	Yes	See above for guidance on an allergic reaction to a COVID vaccine or its components. **Observe the patient for 30 minutes if:** The patient had any immediate allergic reaction of any severity to other vaccines or injectable therapies AND/OR The patient experienced anaphylaxis due to any cause (oral med, food, pet, insect, venom, environmental, latex, etc). AND/OR The patient has a contraindication to a different type of COVID-19 Vaccine.
11.	Yes	Apply firm pressure on the vaccine administration site, without rubbing, for at least 2 minutes.
12.	Yes	Counsel patient about the unknown vaccine safety profile and effectiveness in immunocompromised populations, the potential for reduced immune responses and the need to continue to follow current guidance to protect themselves.
13.	Yes	Persons who have received dermal fillers may develop temporary swelling at or near the filler injection site, usually face or lips, after a dose of an COVID-19 vaccine. Counsel patient to contact their HCP if they experience this reaction.
14.	Yes	ACIP does not state a preference--any of the FDA-authorized COVID-19 vaccines can be administered to pregnant or lactating people. However, pregnant, lactating, and post-partum people aged <50 years should be aware of the rare risk of TTS after receipt of the Janssen COVID-19 vaccine and the availability of other FDA-authorized COVID-19 vaccines. **Pregnancy:** Based on current knowledge, experts believe that COVID-19 vaccines are unlikely to pose a risk to the pregnant person or fetus. However, the potential risks of COVID-19 vaccines to the pregnant person and the fetus are unknown because these vaccines have not been studied in pregnant people. **Lactation:** There are no data on the safety of COVID-19 vaccines in lactating people or the effects of COVID-19 vaccines on the breastfed infant or milk production or excretion.