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 16 years of age or older?			
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? *Immunizer to record patient temperature*			Temp:
4.	In the past month, have you been in contact with someone who has confirmed or suspected Coronavirus/COVID-19?			
5.	Over the last 14 days, have you had any of the following symptoms: cough, fever, loss of smell or taste, shortness of breath, or chills?			
6.	Have you had a positive test or doctor's diagnosis for COVID-19?			
7.	Have you received plasma or monoclonal antibodies for COVID in the past 90 days?			
8.	Have you received any vaccinations in the past 14 days?			
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.	Are you immunocompromised (have a weakened immune system) or are you taking medication that affects your immune system?			
13.	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 Giant Eagle to release my immunization records to Federal and state immunization registries and my health insurance provider. For the vaccine(s) indicated hereon, I acknowledge receipt of the Vaccine Information Sheet (VIS) or EUA Fact Sheet associated with the vaccine described above. Furthermore, I have also 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 below for whom I am the legal guardian. I, for myself, my heirs, executors, personal representatives and assigns, hereby release Giant Eagle, Inc. and its 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 administration of immunization(s) indicated hereon, and affirm that the aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines requested.

Signature (Patient or Legal Guardian): _____Date:_____

Print Full Legal Name: _____

Reviewed: 3/5/21 CG

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Healthcare Provider Only

Patient Name:	DOB:

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 COVID-19 who are 16+ years of age **Moderna and Janssen Vaccines:** Administer to patients desiring immunity to COVID-19 who are 18+ years of age
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 delayed until the illness has improved. Mild illnesses (upper respiratory infections or diarrhea) are NOT contraindications to vaccination. Do not withhold 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 6/20/20). Evaluate any reported symptoms that may be due to COVID-19. 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	The vaccine should be postponed until the patient has been symptom free for at least 14 days.
6.	Yes	Vaccination should be offered to persons regardless of history of prior SARS-CoV-2 infection, although patients may defer vaccination for 90 days post infection because current evidence suggests reinfection is uncommon during this time. Vaccination of persons with known current SARS-CoV-2 infection should be deferred until the person has recovered from the acute illness and criteria have been met for them to discontinue isolation.
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**. A history of a polysorbate allergy is a precaution (not a contraindication) per ACIP 3/3/21. **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 for latex if patient has a **LATEX** allergy. Vaccine vial stoppers do not contain **LATEX.**
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, as well as the potential for reduced immune responses and the need to continue to follow all current guidance to protect themselves against COVID-19.
13.	Yes	**Pregnancy:** Based on current knowledge, experts believe that COVID-19 vaccines are unlikely to pose a risk to the pregnant person or fetus because the currently authorized COVID-19 vaccines are non-replicating vaccines and cannot cause infection in either the mother or the fetus. No evidence exists of risk to the fetus from vaccinating pregnant women with non-replicating vaccines in general. 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 patients or the effects of COVID-19 vaccines on the breastfed infant or milk production or excretion. Because non-live vaccines pose no risk for lactating people or their infants, COVID-19 vaccines are also not thought to be a risk.