AUBURN PHARMACY
"Caring for the health of you and your community"

COVID-19 Vaccine Administration Record, Screening, and Patient Consent

Name:_____ DOB: _____ Age: _____ Gender *(circle one):* M F

Address:_____City:_____State:_____Zip:_____

Phone: _____ Email: _____

Insurance *(mark one)*: ☐ Private or Employer Insurance ☐ Underinsured ☐ Medicare ☐ Medicaid ☐ Uninsured

Medicare ID # *(if applicable):* _____ Social Security Number *(if under or uninsured):* _____

Primary Care Physician (PCP):_____PCP Phone: _____

The following information will be used for COVID-19 Immunization Phase Determination and Reporting Purposes:

List Health Conditions: _____

Employer: _____ Job Title: _____

Race *(circle one):* American Indian/Alaskan Native Asian Black/African American Native Hawaiian/Pacific Islander White Other Unknown

Ethnicity *(circle one):* Not Hispanic Hispanic Unknown

1) Have you ever had a severe reaction to any vaccine requiring medical attention?	**YES**	**NO**
2) Are you allergic to eggs, thimerosal mercury, neomycin, PEG, polysorbate, or gelatin?	**YES**	**NO**
3) Have you received monoclonal antibody treatment for COVID-19 in the last 90 days?	**YES**	**NO**
4) Have you had Guillain-Barre syndrome, seizures, brain or nerve problems?	**YES**	**NO**
5) Are you pregnant or planning to become pregnant in the next 3 months?	**YES**	**NO**
6) Are you, or anyone in your household, being treated with chemotherapy or radiation for cancer, taking oral prednisone (>20mg) or other steroids, have HIV/AIDS or any other immune deficiency disorder?	**YES**	**NO**
7) Do you have a bleeding disorder or take "blood thinners" like Coumadin or heparin?	**YES**	**NO**
8) Have you received any vaccine within the last 2 weeks?	**YES**	**NO**
9) Have you been exposed to anyone diagnosed with COVID-19 in the past 14 days?	**YES**	**NO**
10) Are you experiencing any symptoms of COVID-19 including fever, cough, shortness of breath or loss of taste or smell?	**YES**	**NO**
11) Have you previously been vaccinated with any COVID-19 vaccine? If yes, please complete section below: Vaccine Brand *(Pfizer, Moderna, Astra Zeneca, Johnson & Johnson):* _____ Date dose #1 given: _____ Date dose #2 (if necc) given: _____	**YES**	**NO**

Please read the following statements and sign below on the signature line:

I consent to AuBurn Pharmacy and its staff for my person named at the top of this form to be vaccinated with this COVID-19 vaccine. I have been provided the Emergency Use Authorization Fact Sheet or a Vaccine Information Statement prior to vaccination and have the ability to revoke consent at any time. I believe I understand the benefits and risk of vaccination and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I self-certify that the health and employment information indicated on this form is true to determine COVID-19 vaccine phase eligibility. I do hereby authorize AuBurn Pharmacy to release information and request payment from Medicare or commercial insurance. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf. I consent to inclusion of this immunization data in any state immunization registry for myself or on behalf of the person named below. I consent to having my temperature taken by an AuBurn Pharmacy representative and documented on this screening form.

_____ _____

Signature of person receiving vaccine or authorized representative *Date*

Internal Use Only

Vaccine		Admin Date	
Lot / Exp Date		Location/Route	
Manufacturer		Administrator	
Dose		Administrator Sign.	

☐ Scanned as Rx

☐ Notified PCP
Fax # _____

☐ WebIZ/ShowMeVax

Patient Temp.