



## 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  Uninsured  Medicare  Medicaid

Primary Care Physician (PCP): \_\_\_\_\_ PCP Phone: \_\_\_\_\_

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

List Health Conditions: \_\_\_\_\_

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

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:	YES	NO
Vaccine Brand (Pfizer, Moderna, Astra Zeneca, Johnson & Johnson): _____		
Date dose #1 given: _____ Date dose #2 (if necc) given: _____		

**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

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Internal Use Only

Vaccine		Admin Date	
Lot / Exp Date		Location/Route	
Manufacturer		Administrator	
Dose		Administrator Signature	
Notes/Product Sticker			

Patient Temp.	
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<input type="checkbox"/> Scanned as Rx <input type="checkbox"/> Notified PCP Fax # _____ <input type="checkbox"/> Documented in state immunization registry
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