



Vaccine Administration Record, Screening, and Patient Consent

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

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 Facility Name: _____ Room Number: _____

Authorized POA/Legal Guardian: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance (mark one): Commercially Insured Medicare (Medicare ID: _____) Uninsured (SSN: _____)

Primary Care Physician (PCP): _____ PCP Phone: _____

1) Have you ever had a severe reaction to any vaccine requiring medical attention? If yes, please describe:	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 Guillian-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, have HIV/AIDS, any other immune deficiency disorders, or taking oral prednisone or other steroids?	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): _____ Dose #1 date: _____ Dose #2 date: _____ Dose #3 date: _____ Booster date: _____	YES	NO

Please read the following statements and complete section below providing consent:

I consent to AuBurn Pharmacy and its staff for my person named at the top of this form to be vaccinated with this vaccine for both the initial and second dose in the series, if applicable. 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 have had an opportunity to ask questions that were answered to my satisfaction. 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 do hereby authorize AuBurn Pharmacy to release information and request payment from Medicare or commercial insurance. I certify that the information given by me in applying for payment is correct. 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.

Is patient able to make their own medical decisions? ___ Yes ___ No If yes, Patient Signature: _____ Date: _____

If no, Medical DPOA Name: _____ Medical DPOA Signature: _____ Date: _____

OR Verbal authorization given to Facility Staff Member: _____ Title: _____ Date: _____

Internal Use Only

Admin Date		Administrator		Admin Signature	
Vaccine		Notes/Product Sticker	Vaccine		Notes/Product Sticker
LOT/EXP			LOT/EXP		
Manufacturer			Manufacturer		
Dose			Dose		
Location/Route			Location/Route		

___ Scanned as Rx

___ Faxed PCP

___ WebIZ/SMV