giant eagle pharmacy

COVID-19 Vaccine Immunization Administration Record

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

First Name:	Last Name:	Sex at Birth: □ Male □ Female	
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:		

	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 Janssen COVID-19 vaccination.* ***Males aged 12-29 years:*** *please note the rare risk of myocarditis or pericarditis after receipt of a mRNA vaccine.* ***Patients 5-17 years:*** *only eligible to receive a Pfizer COVID-19 vaccine.*			Age:
2a.	Have you previously received a dose of COVID vaccine? What product? When? Product: Date(s) received:			
2b.	Please choose one of the following that best describes you, if applicable:			OR
OR	I attest that I have a **weakened immune system** and meet the current requirements of the Centers for Disease Control and Prevention (CDC) for a **third dose** of Pfizer or Moderna COVID-19 vaccine.			
2c.	I attest that I meet the current requirements of the Centers for Disease Control and Prevention (CDC) for a **booster dose** of Pfizer, Moderna, or Janssen COVID-19 vaccine.			
	Precautions and Contraindications: *Please check "yes" or "no" for each question.*	**Yes**	**No**	
3.	Are you feeling sick today?			
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 90 days, have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?			
9.	Have you ever had an allergic reaction to a COVID-19 vaccine component (Polyethylene glycol or PEG; POLYSORBATE), or to a previous dose of a COVID-19 vaccine?			
10.	Have you ever had an allergic reaction to another vaccine (other than COVID-19); an injectable medication; or something else, such as food, pet, venom, environment or oral medications?			
11.	Do you have a history of heparin-induced thrombocytopenia (HIT), a bleeding disorder, or are you taking a blood thinner?			
12.	Do you have a history of myocarditis or pericarditis?			
13.	Do you have a weakened immune system or are you taking medication that affects your immune system?			
14.	Do you have a history of Guillain-Barré Syndrome (GBS)?			
15.	Do you have dermal fillers?			
16.	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 Parent/Legal Guardian): _____Date:_____

Print Full Legal Name (Patient or Parent/Legal Guardian): _____

For School Clinics Only: My signature above indicates that I understand that if this release is executed in support of a school-sponsored immunization program, I consent to the person named above, for whom I am a parent or legal guardian, receiving the applicable immunization without me being present on the clinic date of : _____.

Giant Eagle Pharmacy Use 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 or federal regulations.
- Appropriate written education has been provided to the patient, including a Well Child Visit Reminder as applicable.

Signature (Immunizer):_____ Date: _____

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

If Pharmacy Intern, overseeing Pharmacist to sign and print name: _____

If using PREP Act, Ordering Pharmacist signature:_____

Ordering Pharmacist NPI:_____ Ordering Pharmacist License #:_____

Patients 5 - 11 YEARS OF AGE and receiving DOSE 1 or DOSE 2		
□ Pfizer Peds (age 5-11) BioNTech COVID-19 Vaccine **(10 mcg/0.2 mL)** Verify NDC: 59267-**1055**-01 RPH Initials:_____ **Verify dose and volume: (10 mcg/0.2 mL)** RPH Initials:_____	□ Dose 1 (SCC 2) □ Dose 2 (SCC 6) (21 days apart)	Lot Number: Expiration Date: Ordering Provider:
Sig: Administer 1 shot intramuscularly into the: □ Left Deltoid □ Right Deltoid		No Refills

Patients 12 - 17 YEARS OF AGE and receiving DOSE 1, DOSE 2 or DOSE 3 for Immunocompromised Patients			
□ Pfizer BioNTech COVID-19 Vaccine (30 mcg / 0.3 mL) Verify NDC: 59267-**1000**-01 RPH Initials:_____	□ Dose 1 (SCC 2) □ Dose 2 (SCC 6) (21 days apart)	□ Dose 3 (SCC 7) (28 days apart)	Lot Number: Expiration Date: Ordering Provider:
Sig: Administer 1 shot intramuscularly into the: □ Left Deltoid □ Right Deltoid			No Refills

Patients 18+ YEARS OF AGE and receiving DOSE 1 or DOSE 2		
□ Pfizer BioNTech COVID-19 Vaccine (30 mcg / 0.3 mL) Verify NDC: 59267-**1000**-01 RPH Initials:_____	□ Dose 1 (SCC 2) □ Dose 2 (SCC 6) (21 days apart)	Lot Number:
□ Moderna COVID-19 Vaccine (100 mcg / 0.5 mL) Verify NDC: 80777-**273**-10; 80777-**273**-15 RPH Initials:_____	□ Dose 1 (SCC 2) □ Dose 2 (SCC 6) (28 days apart)	Expiration Date:
□ Janssen COVID-19 Vaccine ($5X10^{10}$ viral particles / 0.5 mL) Verify NDC: 59676-**0580**-05 RPH Initials:_____	Dose 1 (SCC 2)	Ordering Provider:
Sig: Administer 1 shot intramuscularly into the: □ Left Deltoid □ Right Deltoid		No Refills

Patients 18+ YEARS OF AGE who are IMMUNOCOMPROMISED and receiving a THIRD DOSE		
□ Pfizer BioNTech COVID-19 Vaccine (30 mcg / 0.3 mL) Verify NDC: 59267-**1000**-01 RPH Initials:_____	Dose 3 (SCC 7) (28 days after Dose 2)	Lot Number:
□ Moderna COVID-19 Vaccine (100 mcg / 0.5 mL) Verify NDC: 80777-**273**-10; 80777-**273**-15 RPH Initials:_____	Dose 3 (SCC 7) (28 days after Dose 2)	Expiration Date: Ordering Provider:
Sig: Administer 1 shot intramuscularly into the: □ Left Deltoid □ Right Deltoid		No Refills

Patients 18+ YEARS OF AGE and receiving a BOOSTER DOSE		
□ Pfizer BioNTech COVID-19 Vaccine (30 mcg / 0.3 mL) Verify NDC: 59267-**1000**-01 RPH Initials:_____	Booster Dose/3 (SCC 10) (6 months after Dose 2)	Lot Number:
□ Moderna COVID-19 Vaccine **(50 mcg / 0.25 mL)** Verify NDC: 80777-**273**-10; 80777-**273**-15 RPH Initials:_____ **Verify dose and volume: (50 mcg / 0.25 mL)** RPH Initials:_____	Booster Dose/3 (SCC 10) (6 months after Dose 2)	Expiration Date:
□ Janssen COVID-19 Vaccine ($5X10^{10}$ viral particles / 0.5 mL) Verify NDC: 59676-**0580**-05 RPH Initials:_____	Booster Dose/3 (SCC 10) (2 months after Dose 1)	Ordering Provider:
Sig: Administer 1 shot intramuscularly into the: □ Left Deltoid □ Right Deltoid		No Refills

Reviewed 11.2.21 CG