COVID-19 Vaccine Administration Record and Informed Consent

Galesville LTC Pharmacy

Section A: Information about Person to Receive Vaccine

Name (Last):	(First):	(M.I.):	Date of Birth:

Age:	Phone Number:

Street Address:	Facility Location of Vaccine Administration:

City:	State:	Zip:

Section B: Screening for Vaccine Eligibility

Covid Vaccine History: No Covid Vaccine Received: ❑

Date dose #1: Date _____ Brand_____

Date dose #2: Date _____ Brand_____

Date dose #3: Date _____ Brand_____

Section C: 3rd or 4th Dose/Booster Attestation

❑ To receive a 3rd dose/1st booster of COVID vaccine, I attest that I am over the age of 18 and either five months from my last Moderna/Pfizer dose or 2 months from my last Janssen dose.

❑ To receive a 4th dose/2nd booster of COVID vaccine, I attest that I am over the age of 50 or over the age of 12 and immunocompromised, and either four months from my last Moderna/Pfizer dose or 4 months from my last Janssen dose.

Section D: Insurance Information

Insurance Carrier:	Patient ID #:	BIN #:	PCN #:	Group #:

Medicare B #:	Social Security #:

Section E: Consent Attestation

I understand I will be provided/offered an Emergency Use Authorization Fact Sheet or a Vaccine Information Statement and have the ability to revoke consent at any time. I give consent to Galesville LTC Pharmacy and its staff to vaccinate the patient named above against the COVID-19 virus.

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(Signature of Patient or Parent / Guardian if under 18 years old) *(Date in Month/Day/Year)*

Section F: **For Pharmacy Use Only**

Vaccine/Manufacturer:		Lot:	Exp:	VIS/EUA Date:	Route:	Site:	Immunizer Sign:
					IM	LA RA	
Dose number in series:	**Dose (mL):**	**Date administered:**	**WIR completed:**	**Rx Entered:**	**Rx #:**		**Rx Paid Claim:**