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:	Facility /Location of Vaccine Administration:

Home Street Address:	City:	State:	Zip:

Section B: Covid Vaccine History

Pfizer	**Moderna**	**Janssen (J&J)**	**Novavax**
1st Dose: ____/____/____	1st Dose: ____/____/____	1st Dose: ____/____/____	1st Dose: ____/____/____
2nd Dose: ____/____/____	2nd Dose: ____/____/____	2nd Dose: ____/____/____	2nd Dose: ____/____/____
3rd Dose: ____/____/____	3rd Dose: ____/____/____		
4th Dose: ____/____/____	4th Dose: ____/____/____		

Section C: Screening

	Yes	No
Are you sick today? (Fever, cough, shortness of breath, nausea/vomiting in the last 24 hours?		
Are you currently in isolation or quarantine due to a recent Covid exposure?		
Have you had a serious reaction to any Covid vaccine in the past?		

To receive a bivalent Covid booster:

- ❑ I attest that 2 months have passed since my primary series OR previous booster dose
- ❑ I am at least 18 years old (Moderna) or at least 12 years old (Pfizer)

Section D: Insurance Information

Insurance Carrier:	Patient ID #:	BIN #:	PCN #:	Rx 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.

_____

(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:**