Vaccine Administration Record

HealthRidge Pharmacy
3130 US 70 HWY
Black Mountain, NC 28711-9108
Phone: (828) 669-9970 Fax: (828) 669-9980

Name: _____ Male: _____ Female: _____ Date of Birth: _____

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

Phone: _____ Email Address: _____ SSN: _____ (if no insurance info available)

Race (circle one): Hispanic or Latino Not Hispanic or Latino Other

Ethnicity (circle one): American Indian Asian Black or African American Caucasian

Screening Questions	Circle
Are you feeling sick today?	Yes No
Have you ever had an allergic reaction to a component of the COVID-19 vaccine, including polyethylene glycol (PEG) or polysorbate or a previous dose of COVID-19 vaccine?	Yes No
Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)	Yes No
Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? (This would include food, pet, venom, environmental, or oral medication allergies.)	Yes No
Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? (This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.)	Yes No
Have you had a stem-cell transplant (hematopoietic cell transplant (HCT) or CAR-T-cell therapies), and received a COVID-19 vaccine before or during that treatment?	Yes No
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? If yes, when did you receive antibody therapy? _____	Yes No
Do you have a bleeding disorder or are you taking a blood thinner?	Yes No
Do you have dermal fillers?	Yes No
Do you have a history of myocarditis or pericarditis?	Yes No
Have you been diagnosed with Multisystem Inflammatory Syndrome?	Yes No
Do you have a history of heparin-induced thrombocytopenia (HIT) or thrombosis with thrombocytopenia syndrome?	Yes No
Do you have a history of Guillain-Barre Syndrome (GBS)?	Yes No
Have you had COVID-19 in the past 3 months?	Yes No

Consent

I request the vaccine to be given to me or to the person named above, a minor for whom I represent and I am authorized to sign this consent form. I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet, a copy of which I was provided with this consent form (online or in print). I have had a chance to ask questions that were answered to my satisfaction. I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur. I understand that I will be receiving the vaccination at no cost to me. If insured, I authorize the pharmacy to bill my insurance on my behalf for the immunization – understanding that I will not incur any costs. If uninsured, I attest that I do not have any insurance, including, but not limited to Medicare, Medicaid, or any other private or government-funded benefit plan. I understand that at this time, some COVID-19 vaccines require 2 doses given 21-28 days apart dependent on the manufacturer. If this is my first dose of the COVID-19 vaccine and a second dose is required (Pfizer, Moderna, and Novavax), I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the series.

Name (print) _____ Signature _____ Date _____

Administration (Pharmacy Use Only)

Vaccine	Product	Series	Lot	Exp Date	Dose	Injection Site	Signature of administrator of vaccine
COVID-19	Pfizer Comirnaty	2023-2024	HG2282	12/9/23	0.3 ml	LD RD	
	Moderna Spikevax	2023-2024			0.5 ml	LD RD	