A to Z Pharmacy

☐ NCIR ☐ Scan ☐ Fax Dr

# COVID-19 Vaccine Administration Form

**Recipient full name:** ______________________________ **Date of birth:** _____________ **Sex: M F**

**Address:** ______________________________ **City:** __________ **State:** ___ **Zip:** _____ **County:** _______

**Age:** ____ **Phone Number:** ________________________ **Primary Care Dr:** _______________________

⬜ I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an 'applicable Provider'), to share my personal, demographic, and health condition information in order to provide me with vaccination services for the COVID-19 vaccine.

**Patient (or Guardian) Signature:** ___________________________________________________

| Question | Response |
|---|---|
| Are you feeling sick today? | Yes No |
| Have you ever received a dose of the COVID-19 vaccine?<br>Please circle type(s) received: **Pfizer** **Moderna** **J&J** **Other**_______ | Yes No |
| Have you ever had an **allergic reaction** to: | |
| ❖ Polyethylene glycol (PEG)-found in some medications, like laxatives & Colonoscopy preps? | Yes No Maybe |
| ❖ Polysorbate, which is found in some vaccines, film-coated tablets, & intravenous steroids | Yes No Maybe |
| ❖ A previous dose of COVID vaccine? | Yes No Maybe |
| ❖ Another 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 Maybe |

___ Female between 18 - 49 years old
___ Male between 12 - 29 years old
___ History of Myocarditis or Pericarditis
___ Have received dermal fillers
___ Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19
___ Have a bleeding disorder or take a blood thinner
___ Have a history of heparin-induced Thrombocytopenia
___ Am currently pregnant or breastfeeding
___ Have a history of Guillain-Barré Syndrome (GBS)
___ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection

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**Dose:** ☐ 1 ☐ 2 ☐ **Booster**

| Injection Site: **LEFT RIGHT** Deltoid Route: **IM**<br><br>VACCINE LABELS HERE | RX LABEL |
|---|---|

Signature of pharmacist who administered vaccine(s) and provided VIS to patient: ______________________________

License # ___18931____9273________ NPI __1720244239____1356643290__ Date _______________

# Parental Consent for Individuals under 18 Years of Age

Currently the U.S. Food and Drug Administration (FDA) has only given full approval for the use of Pfizer-BioNTech Vaccine to prevent COVID-19 in individuals 16 years of age and older.

The FDA has **not** yet fully approved the licensure of vaccines to prevent COVID-19 in patients 5 years of age and older. I have reviewed the FDA fact sheet information on the risks and benefits of the Moderna and Pfizer-BioNTech Vaccines and understand the risks and benefits. I agree that:

1. I have reviewed this consent form and have read & understand the “Fact Sheet for Recipients and Caregivers” about the potential risks and benefits of the Moderna and Pfizer-BioNTech Vaccines.

2. I have legal authority to consent to have the patient named above vaccinated with the Moderna or Pfizer-BioNTech Vaccine.

3. I understand I am not required to accompany the patient named above to the vaccination appointment, and by giving my consent below, the patient will receive the Moderna or Pfizer-BioNTech whether or not I am present at the vaccination appointment.

4. I understand that as required by state law, all immunizations will be reported to the North Carolina Immunization Registry (NCIR) as well as North Carolina COVID Vaccine Management System (CVMS). I understand this information will be treated as confidential medical information, and shall only be shared as allowed by law.

I GIVE CONSENT for the patient named at the top of this form to get vaccinated with Moderna or Pfizer-BioNTech COVID-19 Vaccine and have reviewed and agree to the information included in this form.

Parent/Guardian Name & Signature: ____________________________

Relationship to Patient: __________________

Address (**IF** different from above): ____________________________________________________

Phone number: ________________________

Date: ___________