A to Z Pharmacy

□ NCIR □ Scan □ Fax Dr □ Morris List

2025 COVID-19 Vaccine Administration Form

Recipient full name: _____ **Date of birth:** _____ **Sex:** **M** **F**

Address: _____ **City:** _____ **State:** ___ **Zip:** _____ **Age:** ____

Phone Number: _____ **Primary Care Dr:** _____

By signing, I give my consent to the licensed healthcare provider administering the vaccine, as applicable, to share my personal, demographic, and health condition information to provide me with vaccination services for the COVID-19 vaccine.

Patient (or Guardian) Signature: _____

Are you feeling sick today?	Yes No
Have you ever received a dose of the COVID-19 vaccine?	Yes No
Which vaccine would you like to receive today?	Pfizer Moderna
Have you ever had an **allergic reaction** to: ❖ Polyethylene glycol (PEG)-found in some medications, like laxatives & Colonoscopy preps? ❖ Polysorbate, which is found in some vaccines, film-coated tablets, & intravenous steroids? ❖ A previous dose of COVID vaccine? ❖ Another vaccine **that required treatment with epinephrine** 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 Yes No Yes No Yes No

Risk Factors for Adverse Events:

___ Female between 18-49 years old
___ Male between 12-29 years old
___ History of Myocarditis or Pericarditis
___ Have a bleeding disorder or take a blood thinner
___ Multisystem Inflammatory Syndrome after a COVID-19 infection
___ Have a history of heparin-induced Thrombocytopenia
___ Have received dermal fillers
___ Have a history of Guillain-Barré Syndrome (GBS)

Risk Factors for Severe COVID:

___ Asthma or any chronic lung problems
___ Cancer of any kind
___ Depression, Mood disorders, or Schizophrenia
___ Chronic Liver disease
___ HIV or AIDS
___ Kidney disease
___ History of organ or blood stem cell transplant
___ Age 65 or older
___ Live in a group home
___ Type 1 or 2 Diabetes
___ Down Syndrome
___ Obesity (BMI ≥30 or ≥95th percentile in children)
___ Physical Inactivity
___ Heart disease (heart failure, CAD, cardiomyopathy)
___ Smoking
___ Using Immunosuppressive medications
___ Currently pregnant or breastfeeding
___ Caregiver for any patient at risk for severe COVID

Injection Site: **LEFT** **RIGHT** Deltoid Route: **IM** VACCINE LABELS HERE	RX LABEL	W B A H O M F M 3 C

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

License # 18931 30531 _____ NPI 1720244239 1962074591 Date _____