COVID-19 Vaccine Administration Record and Screening

Today's Date: ___________

Information collected on this form will be used to document authorization for receipt of vaccines. The information will be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and confidential.

Patient information: (Patient to complete)

Name:__________________________________ **Gender:** Male / Female **Phone:**__________________

Birth Date:_____________ **Age:**________ **Mothers Maiden Name:** _______________________________

Address:____

City:___________________ **State:**________ **ZIP:**______________

Medicare Part A & B ID # (red/white/blue card): ______________________________

Other Insurance: ID________________ RX BIN___________ PCN _____________ RX GROUP_____________

Primary Care Physician:___________________________________

Questions for Patient Receiving Vaccine		**Yes**	**No**
1.	Are you feeling sick today? (fever, cough, shortness of breath, nausea/vomiting in the last 24 hours?)	☐	☐
2.	Have you ever received a dose of COVID vaccine? ▪ If yes, which vaccine product and date received? ☐ Pfizer ___________ ☐ Janssen (Johnson&Johnson)__________ ☐ Moderna_____________ ☐ Another product ___________________	☐	☐
3.	Have you had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine (EpiPen), or for which you had to go to the hospital?	☐	☐
4.	Have you received another vaccine in the last 14 days?	☐	☐
5.	Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? If yes, what was the date of your positive test? ________	☐	☐
6.	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐
7.	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐
8.	Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐
9.	Are you pregnant or breastfeeding?	☐	☐
10.	Have you reviewed the fact sheet provided to you on the vaccine you will be receiving?	☐	☐

I have been given a copy and have read, or have had explained to me, information about the diseases and the vaccine to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risk of receiving a vaccine approved under an Emergency Use Authorization from the FDA. I consent to receive the vaccine in a public location. I have been made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors. I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me, or in the case that I am a guardian, my child.

Patient Signature (or representative) ________________________________ **Date:**_____________

Are you receiving ☐ Dose 1 or ☐ Dose 2 or ☐ Booster Dose 1 or ☐ Booster Dose 2

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PHARMACY USE ONLY

Vaccine:

Lot #:________________________

Exp Date:____________________

Site: RA or LA

☐ Vaccine Fact Sheet Provided

Vaccine Administrator: Seth Moe, PharmD, or Stevie Moe, PharmD

______________________________________Title: Registered Pharmacist ___________________

Signature of Administrator Date

Three Lakes Pharmacy

PO Box 437
1790 Superior St, Three Lakes, WI 54562

www.threelakespharmacy.com