

# 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:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**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?)	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever received a dose of COVID vaccine? If yes, which vaccine product and date received? <input type="checkbox"/> Pfizer _____ <input type="checkbox"/> Janssen (Johnson&Johnson) _____ <input type="checkbox"/> Moderna _____ <input type="checkbox"/> Another product _____	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you received another vaccine in the last 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you pregnant or breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you reviewed the fact sheet provided to you on the vaccine you will be receiving?	<input type="checkbox"/>	<input type="checkbox"/>

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?

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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 Wessel, PharmD

\_\_\_\_\_  
Signature of Administrator

Title: Registered Pharmacist

\_\_\_\_\_  
Date

**Three Lakes Pharmacy**

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