COVID-19 Vaccine Administration Record

Harbor Town Pharmacy
103 Harbor Town Sq, Unit 107
Memphis, TN 38103-8884
Phone: (901) 347-2774 Fax: (901) 347-2778

Patient Information (Vaccine Recipient):

Name (Last): _____ Name (First): _____ Name (Middle): _____
Date of Birth: _____ Gender: _____ Race: _____ Race: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone Number: _____
Primary Care Physician & Phone Number: _____
Emergency Contact Name: _____ Relation: _____ Phone Number: _____
Mother's Maiden Name: _____

Question	YES	NO	DON'T KNOW
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 Vaccine?			
3. Have you ever had an allergic reaction to: (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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing .)			
• **A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures**			
• **Polysorbate**			
• **A previous dose of COVID-19 Vaccine**			
4. 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing .)			
5. 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, environmental, or oral medication allergies?			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? *[note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]*			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			

NAME (PRINTED) _____ **SIGNATURE** _____ **DATE** _____

****PHARMACY USE ONLY****

Vaccine	Dose	Route	Date Dose Administered	NDC	Lot Number	Expiration Date	Name of Vaccine Administrator
Pfizer-Biontech COVID-19	☐ 1st Dose ☐ 2nd Dose ☐ 3rd Dose ☐ 4th Dose	☐ IM - L Arm ☐ IM - R Arm		☐ 59267-1025-01 (Gray,Comirnaty) ☐ 59267-1055-01 (Orange, 5-11)			

Pharmacist Signature: _____ **TennIIS**: _____

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Name: _____ **Date Of Birth:** _____

Consent (check each box below after reading and signing)

☐ 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. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent Form.

☐ 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, **please bring in your prescription and medical insurance cards** for your vaccine appointment. I authorize the pharmacy to bill my insurance on my behalf for the immunization - understanding I will not incur any costs.

COVID-19 Vaccine - Bivalent Booster Dose Self-Attestation of Eligibility
PEOPLE WHO ARE ELIGIBLE FOR A BIVALENT BOOSTER DOSE OF COVID-19 VACCINE

If you meet the criteria outlined by the CDC (listed below), you are eligible for a BIVALET booster dose of the COVID-19 vaccine. Patients should contact their primary care provider with any questions about their eligibility, medical considerations, timing, and to see if a BIVALENT booster dose is appropriate for them.

By checking the box below, I (or legally authorized representative) attest that I (the patient) am eligible for a bivalent booster dose of vaccine based on one of the following criteria.

☐ Pfizer-BioNTech

I am 12 years of age or older AND at least 2 months ago:

- Completed a primary series of a COVID-19 vaccine OR
- Received the most recent booster dose with any authorized or approved monovalent COVID-19 vaccine

Signature of Person to Receive Vaccine & EUA /VIS (or Signature of Parent/Guardian if Patient is < 18 years old):

Signature:_____ **Date:**_____