SILVERTON PILL BOX

Bag tag

COVID-19 Vaccine Administration Record

302 N First Street Silverton, OR 97381 503-873-6321

Patient Information **Gender: Male Female Other**

Race: ☐ **African American** ☐ **American Indian/Alaskan Native**

☐ **Asian** ☐ **Native Hawaiian/Pacific Islander** ☐ **White**

☐ **Decline Answer** **Primary Language:** _____

Ethnicity: Hispanic? Yes ☐ **No** ☐ **Decline** ☐

Patient Screening Questions **Temperature** _____			
	Select One:		
Do you have a fever or feel sick today?	**Yes**	**No**	
Have you ever received a dose of COVID-19 vaccine? If Yes, which vaccine product? Pfizer Moderna Other	**Yes**	**No**	**Don't Know**
Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?	**Yes**	**No**	**Don't Know**
Was the severe allergic reaction after receiving a COVID-19 vaccine?	**Yes**	**No**	**Don't Know**
Was the severe allergic reaction after receiving another vaccine or another injectable medication?	**Yes**	**No**	**Don't Know**
Have you received another vaccine in the last 14 days?	**Yes**	**No**	
Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	**Yes**	**No**	**Don't Know**
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	**Yes**	**No**	**Don't Know**
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	**Yes**	**No**	
Do you have a bleeding disorder or are you taking a blood thinner?	**Yes**	**No**	
Has the patient ever fainted after injections?	**Yes**	**No**	
Are you pregnant or breastfeeding?	**Yes**	**No**	

I received a current copy ____EUA_____ of the CDC Vaccine Information Statement (VIS). I have read/had explained to me the information on the VIS and my questions have been answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I agree that neither the Immunizing Pharmacist, Rice's Pharmacy, nor their sponsors shall have any responsibility or liability in association with an adverse reaction following administration of the vaccine. I have received Rice's Pharmacy HIPAA Notice of Privacy Practices Information Sheet. I allow the release of any information needed to process insurance claims and request payment of medical benefits be made to provider.

Signature: _____ Date: _____

Signers relationship to patient: (circle one) Self Mother Father Guardian/Caregiver

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Vaccine Given: _____Moderna COVID-19 vaccine (EUA) 0.5 ml_____ Lot: _____ Exp. Date: _____

Location/Method: _____ RPH: _____ Adolescent Form: Yes No Site/Route: Left Deltoid IM Right Deltoid IM

ALERT IIS Review: _____ ALERT IIS Recorded: _____