THE FRED W. ALBRECHT GROCERY CO. / ACME PHARMACY
COVID-19 VACCINE ADMINISTRATION RECORD

FOR PATIENTS TO BE VACCINATED: The following questions will help us determine if there is any reason we should not give you the COVID-19 vaccination today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your pharmacist to explain it.

1. Are you feeling sick today?	**_____YES _____NO**
2. Have you ever received a dose of COVID-19 vaccine?	**_____YES _____NO**
• If yes, which vaccine product? □ Pfizer □ Moderna □ Another product	
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something?	**_____YES _____NO**
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**
• Was the severe allergic reaction after receiving a COVID-19 vaccine?	**_____YES _____NO**
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?	**_____YES _____NO**
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	**_____YES _____NO**
5. Have you received another vaccine in the last 14 days?	**_____YES _____NO**
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	**_____YES _____NO**
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?	**_____YES _____NO**
8. Do you have a bleeding disorder or are you taking a blood thinner?	**_____YES _____NO**
9. Are you pregnant or breastfeeding?	**_____YES _____NO**

INFORMATION ABOUT THE PERSON TO RECEIVE VACCINE (please print)

Name _____ **Birthday** _____ **Gender** M F
First MI Last mm / dd / yyyy

Race _____ Asian _____ African American _____ Hispanic _____ Caucasian _____Pacific Islander _____ Two or More _____Other

Ethnicity _____Hispanic or Latino _____ Not Hispanic or Latino _____Decline to state (unknown)

Address _____ **Phone** _____
Street City State Zip

Family Doctor _____ **Doctor's Office Phone** _____

Insurance Name _____ **Insurance Member ID #** _____

Driver's License/State ID and number (need for billing for uninsured) _____

CONSENT FOR VACCINATION

I have read the COVID-19 Vaccine Information Statement and understand the risks and benefits of the vaccine. I have had a chance to ask questions. I give permission for an Acme Pharmacist to administer the vaccine and notify my provider. I authorize the release of any medical information necessary to process this claim and request payment of government benefits either to myself or to the party who accepts assignment.

Signature of Patient/Legal Guardian: _____ **Date:** _____

FOR CLINIC / OFFICE USE	
Clinic / Office Address	ACME #
Date Vaccine / VIS Administered VIS Dated	
Vaccine Manufacturer	
Vaccine Lot Number	
Vaccine Expiration Date	
Site of Deltoid IM Injection Dose	L R Dose: 1 2
Strength/Dose Given & Route	Notes: 0.3 ml ____ 0.5ml____ IM
Check Box Once VAR Faxed to PCP	□

Signature of Vaccine Administrator: _____ MO# 521 Order # 708150 1/6/21