giant eagle pharmacy

COVID-19 Vaccine Immunization Administration Record

*Pharmacy Reminder: Copy ID, Medicare B Card, Medical Ins Card, and RX Ins Card

First Name:	Last Name:		□ Male □ Female
Address:	City:	State:	Zip:
Phone:	Social Security Number:		
Population/Occupation:	Birthdate:	Age:	Weight(Lb):
Race: □ American Indian or Alaska Native	□ Asian	□ Black or African American	
□ Hawaiian or Other Pacific Islander	□ White	□ Unknown/Not Reported	
Ethnicity: □ Hispanic or Latino	□ Not Hispanic or Latino	□ Unknown/Not Reported	
Primary Care Physician (PCP) First Name:	PCP Last Name:		
PCP Address:			
PCP Phone:	PCP Fax:		

	Indications: *Please check "yes" or "no" for each question.*	**Yes**	**No**	**Notes**
1.	**Are you 18 years of age or older?** ***Women aged 18-49 years:*** *please note the rare risk of blood clots with low platelets following Janssen COVID-19 vaccination****. Males aged 12-29 years:*** *please note the rare risk of myocarditis or pericarditis after receipt of a mRNA vaccine.* ***Patients 12-17 years:*** *only eligible to receive Pfizer COVID-19 vaccine.*			Age:
2a.	Have you previously received a dose of COVID vaccine? What product? When? Product: Date(s) received:			
2b.	If requesting a third dose of Pfizer or Moderna COVID-19 vaccine: I attest that I am eligible for an additional dose of vaccine and meet the current requirements of the Centers for Disease Control and Prevention (CDC).			
	Precautions and Contraindications: *Please check "yes" or "no" for each question.*	**Yes**	**No**	
3.	Are you feeling sick today?			
4.	In the past 14 days, have you been in contact with someone who has confirmed or suspected COVID-19?			
5.	In the past 10 days, have you had any of the following symptoms: cough, fever, loss of smell or taste, shortness of breath, chills, fatigue, muscle or body aches, headache, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?			
6.	In the past 10 days, have you had a positive test or doctor's diagnosis for COVID-19?			
7.	In the past 90 days, have you received plasma or monoclonal antibodies for COVID-19?			
8.	In the past 90 days, have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?			
9.	Have you ever had an allergic reaction to a COVID-19 vaccine component (Polyethylene glycol or PEG; POLYSORBATE), or to a previous dose of a COVID-19 vaccine?			
10.	Have you ever had an allergic reaction to another vaccine (other than COVID-19); an injectable medication; or something else, such as food, pet, venom, environment or oral medications?			
11.	Do you have a history of heparin-induced thrombocytopenia (HIT), a bleeding disorder, or are you taking a blood thinner?			
12.	Do you have a history of myocarditis or pericarditis?			
13.	Do you have a weakened immune system or are you taking medication that affects your immune system?			
14.	Do you have a history of Guillain-Barré Syndrome (GBS)?			
15.	Do you have dermal fillers?			
16.	For women: Are you pregnant or nursing?			

Consent for services, medical records, and HIPAA privacy information

Medicare/Medigap Policy Holders: I request and assign payment of authorized Medicare and/or Medigap benefits, as applicable, to be made on my behalf to Giant Eagle Pharmacy for any products or services furnished by them to me. I authorize the release of medical information about me to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents as necessary to determine benefits payable for these or related services.

All Patients: I acknowledge receipt of Giant Eagle's Notice of Privacy Practices and authorize the release of immunization information to Federal and state authorities and to any covering health insurance provider(s). For the vaccine(s) indicated hereon, I acknowledge receipt of the relevant Vaccine Information Sheet (VIS) or EUA Fact Sheet. I affirm that I have had the opportunity to ask questions and that I voluntarily assume full responsibility for any reactions that may result. I request administration of the immunization(s) to me or to the patient identified hereon for whom I am the legal guardian. I, for myself, my wards, heirs, executors, personal representatives and assigns, hereby release Giant Eagle, Inc., the hosting facility and its managing and operating companies and owners, the event sponsors, and each entity's respective affiliates, subsidiaries, divisions, directors, contractors, agents and employees, from any and all claims arising out of, in connection with, or in any way related to, the receipt or administration of the immunization(s) indicated hereon. Further, I affirm that I request and access these services at my own risk and will not hold the aforementioned parties, to any extent whatsoever, liable, responsible, or in any way accountable for any loss, physical or personal injury, death, or damages suffered or sustained at any time in connection with or as a result of their offering of this vaccine program, the administration or receipt of the vaccines requested, or access to or use of the hosting facilities.

Signature (Patient or Parent/Legal Guardian): _____Date:_____

Print Full Legal Name (Patient or Parent/Legal Guardian): _____

Reviewed: 8/13/21 CG

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Giant Eagle Pharmacy Use Only

Patient Name:	DOB:

By signing below, I agree that as the immunizing healthcare professional:

- I reviewed the patient's information and screening question responses.
- This vaccine is appropriate for this patient based on the responses to the screening questions and age guidelines according to ACIP recommendations, Giant Eagle's current vaccine protocols, and state regulations.
- Appropriate written education has been provided to the patient, including a Well Child Visit Reminder as applicable.

Signature (Immunizer):_____ Date:_____

Print Name (Immunizer):_____Title (Immunizer):_____

If Pharmacy Intern, overseeing Pharmacist to sign and print name: _____

Vaccine: □ Pfizer BioNTech COVID-19 Vaccine (0.3 mL) IM Dose:_____	**Lot Number:**
□ Moderna COVID-19 Vaccine (0.5 mL) IM Dose:_____	**Expiration Date:**
□ Janssen COVID-19 Vaccine (0.5 mL) IM	**Ordering Provider:**
Sig: Administer 1 shot intramuscularly into the: □ Left Deltoid □ Right Deltoid	**No Refills**

Question	Response	Screening Questions Reference **Depending on state specific guidelines**
1.	Yes/No	**Pfizer Vaccine:** Administer to patients desiring immunity to SARS-CoV-2 who are 12+ years of age. **Moderna and Janssen Vaccines:** Administer to patients desiring immunity to SARS-CoV-2 who are 18+ years of age. Counsel women younger than 50 years old on the rare risk of blood clots with low platelets following Janssen COVID-19 vaccination. Counsel males 12-29 years of age on the risk of myocarditis or pericarditis after receipt of a mRNA vaccine.
2a/2b.	Yes	**Pfizer Vaccine** should be administered as a 2-dose series at least 21 days apart. **Moderna Vaccine** should be administered as a 2-dose series at least 28 days apart. **Janssen Vaccine** is administered as a single dose. Vaccines are NOT interchangeable. Patients eligible for a third dose of Pfizer or Moderna vaccine should receive it at least 28 days after their second dose.
3.	Yes	As a precaution with moderate or severe acute illness, all vaccines should be deferred until the illness has improved. Mild illnesses are NOT contraindications to vaccination. Do not defer vaccination if a person is taking antibiotics. Evaluate any reported symptoms that may be due to SARS-CoV-2 infection. Vaccination of persons with current SARS-CoV-2 infection should be deferred until the person has recovered from acute illness and they can discontinue isolation.
4.	Yes	Defer vaccination until it has been determined that the patient no longer poses a coronavirus transmission risk.
5.	Yes	Defer vaccination until the patient has been symptom free for at least 10 days.
6.	Yes	Vaccination of persons with current SARS-CoV-2 infection should be deferred until the person has recovered from acute illness and they can discontinue isolation. Vaccination should be offered to persons regardless of history of prior SARS-CoV-2 infection. There is no recommended minimum interval between infection and vaccination.
7.	Yes	Vaccination should be deferred for at least 90 days, as a precautionary measure until additional information becomes available, to avoid interference of the antibody treatment with vaccine-induced immune responses.
8.	Yes	Current evidence suggests that the risk of SARS-CoV-2 reinfection is low in the months after initial infection, people with a history of MIS-C or MIS-A should consider delaying vaccination until they have recovered from their infection and for 90 days after the date of diagnosis of MIS-C or MIS-A.
9.	Yes	**Pfizer and Moderna Vaccines:** DO NOT administer the vaccine to patients with a severe allergic reaction or immediate allergic reaction of any severity to a previous dose of the vaccine, or to any component of the vaccine, including **PEG**. **Janssen Vaccine:** DO NOT administer the vaccine to patients with a severe allergic reaction or immediate allergic reaction of any severity to any component of the vaccine, including **POLYSORBATE**. **Observe the patient for 30 minutes** if the patient has a contraindication to a different type of COVID-19 Vaccine.
10.	Yes	**Observe the patient for 30 minutes** if the patient had: any immediate allergic reaction of any severity to other vaccines or injectable therapies AND/OR experienced anaphylaxis due to any cause (food, pet, venom, environment or oral medications).
11.	Yes	**History of HIT:** Offer patients Pfizer or Moderna COVID-19 vaccine if it has been 90 days or less since their illness resolved. After 90 days, patients may be vaccinated with any FDA-authorized COVID-19 vaccine. **Bleeding Disorder:** Any COVID-19 vaccine may be given to these patients, if a physician familiar with the patient's bleeding risk determines that the vaccine can be administered intramuscularly with reasonable safety. **Bleeding Disorder AND/OR Blood thinner:** Apply firm pressure on the vaccine administration site for at least 2 minutes.
12.	Yes	People who have a history of myocarditis or pericarditis unrelated to mRNA COVID-19 vaccination may receive any FDA-authorized COVID-19 vaccine after the episode of myocarditis or pericarditis has resolved. Patients who develop myocarditis or pericarditis after dose 1 of mRNA COVID-19 vaccine should defer dose 2 until additional safety data are available.
13.	Yes	Counsel patient about the unknown vaccine safety profile and effectiveness in immunocompromised populations, the potential for reduced immune responses and the need to continue to follow current guidance to protect themselves.
14.	Yes	People with a history of GBS can receive any FDA-authorized COVID-19 vaccine. However, given the possible association between the Janssen COVID-19 Vaccine and an increased risk of GBS, discuss the availability of mRNA vaccines with patient.
15.	Yes	Patients might experience temporary swelling at or near the site of filler injection (usually the face or lips) following administration of a dose of a COVID-19 vaccine. Counsel patient to contact their HCP if they experience this reaction.
16.	Yes	Pregnant or lactating patients are eligible for and can receive any currently authorized COVID-19 vaccine. However, women aged less than 50 years should be aware of the rare risk of TTS after receipt of the Janssen COVID-19 vaccine and the availability of other COVID-19 vaccines. **Pregnancy:** A growing body of evidence on the safety and effectiveness of COVID-19 vaccination – in both animal and human studies – indicates that the benefits of vaccination outweigh any known or potential risks of COVID-19 vaccination during pregnancy. **Lactation:** There is limited data on the safety of COVID-19 vaccines in lactating people or the effects of COVID-19 vaccines on the breastfed infant or milk production or excretion.