COMMUNITY PHARMACIES

○ Randolph	1447247846	○ Gorham	1538156807	○ Cornish	1760587232
○ Bucksport	1881681286	○ Corinth	1700873122	○ Waldoboro	1124362934
○ Saco	1275520686	○ Blue Hill	1013961549	○ Hermon	1538536180

VACCINE CONSENT & ADMINISTRATION RECORD

Last Name:	**First Name:**	**MI:**	**Gender:** (assigned at birth) ○ Male ○ Female
Address:	**City:**	**State:**	**Zip Code:**
Phone Number: ○ Cell ○ Home	**Primary Care Provider:**	**Date of Birth:**	**Age In Years:**

Race *****Required***
○ White ○ American Indian or Alaska Native ○ Asian ○ Native Hawaiian or other Pacific Islander ○ Black or African American ○ Other

Ethnicity *****Required***
○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Medicare Eligible? Yes No	**If yes, Medicare B Number:** (red, white & blue card)	**OR**	**Social Security #:**	***AND***	**License or State ID:**

Prescription Insurance Name:	**Policy Number:**	**Rx BIN:**	**Rx PCN:**	**Rx Group:**

Uninsured? Yes No By selecting **YES** I am attesting that I do not have insurance	**License or Social Security Number *Required*:**	***Staff—Information Verified?*** ***Yes:*** _____ ***Initials:*** _____

Please read and answer the questions below for the person receiving the vaccine(s) today	**YES**	**NO**	**Don't Know**	**Comment**
1- Do you feel sick today?				
2- Do you have allergies to medications, food latex or any vaccines?				
3- Have you ever had a serious reaction after receiving a vaccination?				
4- Do you have cancer, leukemia, AIDS, or any other immune system problem?				
5- Do you take cortisone, prednisone, or other steroids or anticancer drugs, or xray treatments?				
6- Do you have a seizure, brain or nerve problem?				
7- During the past year, have you received a transfusion of blood or blood products?				
8- Have you been given a medicine called immune (gamma) globulin?				
9- Have you been diagnosed or tested positive for COVID-19 in the last 14 days?				
10- In the past 14 days have you been identified as a close contact to someone with COVID-19?				
11- For women: Are you pregnant or is there a chance you could become pregnant in the next month?				
12- Have you received <u>any other</u> vaccinations in the past 4 weeks. Ex: pneumonia, shingles, flu				
13- Is this your first or second dose of COVID-19 vaccine? (circle one)		FIRST	SECOND	

Please read the following statements and sign below:

I have read, or have had read to me, the information regarding the vaccine(s) being administered today. I have had the opportunity to ask questions that were answered to my satisfaction. I have been informed to wait at least 15 minutes after vaccine administration. I give my permission for the pharmacist providing this immunization to administer epinephrine, diphenhydramine, or both, to me in the case of an adverse reaction to the drug or immunization administered. I understand the benefits and risks of the vaccine(s). I acknowledge that I have been offered a copy of the pharmacy's Notice of Privacy Policies. I consent to, or give consent for, the administration of the vaccine.

Signature:_____ **Date:**_____

For Clinic Use:	
Date Administered:	
Vaccine Name:	
Manufacturer:	
Lot Number:	
Expiration Date:	
Route:	
Site:	
Dose:	
VIS Version (pub date):	
Date and to whom VIS provided:	
Vaccine Administrator:	

Pharmacy Label