PFIZER

CHRISTIANSBURG PHARMACY

Today's Date: _____/_____/_____

☐ **1St Dose** (0.3mL) ☐ **2nd Dose** (0.3mL) ☐ **3rd Dose (Immunocompromised)** (0.3mL) ☐ **Booster Dose (+6mo from 2nd Dose)** (0.3mL)

5 - 11 YEARS OF AGE ONLY

☐ ***1St Dose (0.2mL)*** ☐ ***2nd Dose (0.2mL)***

Patient Name: _____ **Date of Birth:** _____/_____/_____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Gender:** **Male** □ **Female** □ Ethnicity: _____

Drug Allergies: _____ □ **None Known**

The following questions will help us to determine which vaccines may be given today. If a question is not clear, please ask the pharmacist for help.	**Yes**	**No**	**I don't know**
Are you feeling sick today?			
Have you ever received a dose of COVID-19 vaccine?			
If yes, which vaccine did you receive? □ Pfizer □ Moderna □ Janssen			
Do you have allergies to medications, food (i.e. eggs), latex or any vaccine component (i.e. polyethylene glycol (PEG), sorbate, polysorbate, neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast or yeast)?			
Have you ever had a serious reaction after receiving a vaccination?			
Have you received any vaccinations in the past 14 days?			
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 in the last 90 days?			
Have you ever had a positive COVID-19 test or has a provider said that you have COVID-19?			
Have you been exposed to another person with known COVID-19 disease in the last 14 days?			
Do you have a neurological disorder such as seizures or other disorders that affect the brain or have had a disorder that resulted from a vaccine (i.e. Guillain-Barre Syndrome)?			
Do you have cancer, leukemia, AIDS, or an immune system disorder?			
Do you have a bleeding disorder or are you taking a blood thinner?			
Are you pregnant or breastfeeding?			

*** * * CONTINUE ON NEXT PAGE * * ***

I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid or other third party payer as needed and request payment of authorized benefits to be made on my behalf to Christiansburg Pharmacy.

- I acknowledge that if my insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.
- I acknowledge that my vaccination record may be shared with federal or state agencies for registry reporting.
- **I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area, after the administration of the immunization, for 20 minutes or until verbally released.**
- I have read, or have had read to me the Vaccination Information Sheet (VIS) regarding the vaccine(s). I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccines(s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Christiansburg Pharmacy, its affiliates, their officers, directors, and employees from any liability for illness, injury, or damage which may result there from.
- **I authorize Christiansburg Pharmacy to send copies of my vaccine documents to my primary care provider. YES NO**
  I understand failure to select one of these boxes may result in the vaccine documents being sent to my primary care provider, if known, as state laws and regulations require.
- *(OPTIONAL) I request Christiansburg Pharmacy to notify the following contact(s) of this vaccination record (e.g. school, employer, travel agency, etc.):* _____

x _____

Patient Signature *(If under the age of 18: Parent/Legal Guardian signature)*

_____

Parent/Legal Guardian Printed Name

* * PLEASE RETURN THIS FORM TO OUR STAFF AND PROVIDE YOUR LATEST INSURANCE INFORMATION IF NOT ALREADY ON FILE. THANK YOU! * *

THIS SECTION FOR PHARMACY USE ONLY

	Pfizer (COVID-19) ☐ 0.3 mL (30mcg) (Purple Cap) ☐ 0.2 mL (10mcg) (Orange Cap)	

Lot #: _____ Lot #: _____

Exp Date: _____ Exp Date: _____

Site: **LA** or **RA** or OTHER:_____ Site: **LA** or **RA** or OTHER:_____

Signature of pharmacist who administered vaccine(s) and provided VIS to patient: _____

License #: _____ Date: _____