

Vaccine Administration Record

Platte Valley Pharmacy  
 1610 Prairie Center Parkway  
 Suite 2110  
 Brighton CO 80601

Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Primary Care Physician Name and Address: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Medicare # (including letters): \_\_\_\_\_  
 Ethnicity (optional): Caucasian \_\_\_\_\_ African American \_\_\_\_\_ Hispanic \_\_\_\_\_ Asian \_\_\_\_\_ American Indian \_\_\_\_\_ Other \_\_\_\_\_

Screening Questions

- |  |     |    |
|--|-----|----|
| 1. Are you sick today?   | YES | NO |
| 2. Do you have any allergies to medications, foods, latex? If yes, please list _____   | YES | NO |
| 3. Have you ever had a serious reaction to a previous dose of vaccine or any medication?   | YES | NO |
| 4. Have you had a severe allergic reaction to anything?  | YES | NO |
| 5. Have you ever had a severe allergic reaction to any component of the COVID-19 vaccine?  | YES | NO |
| 6. Are you pregnant or breastfeeding, or is there a chance you could become pregnant in the next 14 days?  | YES | NO |
| 7. Have you received any vaccinations in the past 14 days?   | YES | NO |
| 8. Have you been ill or recovered from a COVID infection or had antibody therapy in the last 3 months?   | YES | NO |
| 9. Do you have any of the following illnesses or conditions?<br>Chronic lung disease (including asthma), heart disease, diabetes, brain , spinal cord, or muscle illness that causes swallowing or lung problems, problems with the immune system caused by medications and/or HIV, kidney disease, liver disease, blood disorders   | YES | NO |
| 10. Have you had a COVID vaccine Before<br>Which vaccine Moderna _____ Pfizer _____ Other _____  | YES | NO |
| 11. Please identify which Phase Category you are in:<br>_____ Phase 1A - Highest Risk: Direct contact with COVID Patients, LTC staff/residents<br>_____ Phase 1B.1 People age 70+, moderate-risk health care workers, first responders,<br>_____ Phase 1B.2 - Higher-risk individuals: Age 65-69, pre - K12 Educators Child care workers<br>_____ Phase 1B.3 – People over the age of 60. People 18-59 with 2 or more High Risk conditions<br>Front Line essential workers in Grocery or Agriculture |     |    |

I have received a Notice of Privacy Practice for HIPAA. I have read, or have had read to me, the EUA information for the COVID vaccine I am receiving I have been able to ask questions about the vaccine, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine. I consent to the administration of the vaccine requested. I understand that the vaccination information will be shared with the state immunization database. I agree to stay in the general area for 15-30 minutes after receiving my vaccination in case any immediate reactions occur. If I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); the subsidiaries and affiliates of the pharmacy; the respective directors, officers, employees, and agents of the pharmacy and its subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination.

Name(print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

For Pharmacy Use Only

Signature and Date of vaccine administrator \_\_\_\_\_

By signing as administrator you are confirming that contraindications and side effects have been reviewed and a current VIS was provided to the patient receiving the vaccine.

Site of Injection LD or RD

Manufacturer Moderna Pfizer Janssen

Lot and Expiration Date: \_\_\_\_\_