WARREN'S DRUG STORE

"Experience Independent Pharmacy Care At Its Best"

COVID-19 VACCINE ADMINISTRATION RECORD

NAME _____ DATE OF BIRTH _____ PHONE# (_____) _____ - _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

-Have you ever had a severe reaction to any previous vaccination, including COVID-19?	YES	NO	
-Do you have any allergies to medications, foods, vaccines, latex or carry an Epipen	YES	NO	
-Are you sick today or do you currently have a fever, diarrhea, vomiting or infection?	YES	NO	
-Have you in the last 10 days experienced a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?	YES	NO	
-Have you ever received a dose of COVID-19 vaccine?	YES	NO	
*If yes, which vaccine product? Pfizer Moderna J&J Other_____			
-Have you had any other vaccination in the last 14 days?	YES	NO	
-Have you tested positive for and/or been diagnosed with COVID-19 in the last 90 days	YES	NO	
*If yes, (circle one) asymptomatic symptomatic			Date: ___/___/_____
-Have you received any form of passive antibody therapy for COVID-19?	YES	NO	
*If yes, (Date of therapy administration)			Date: ___/___/_____
-Do you have a bleeding disorder or are you taking a blood thinner?	YES	NO	
-Are you immunocompromised or on a medication that affects your immune system?	YES	NO	
*If yes, did your physician recommend you get the COVID vaccine? Dr. _____	YES	NO	
-Do you have any CHRONIC health conditions? If yes, please list: _____	YES	NO	
-WOMEN ONLY: Is it possible that you are pregnant or breastfeeding?	YES	NO	

I certify that I am: (a) the patient listed above and at least 18 years of age, (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age, or (c) authorized to consent for vaccination for the patient named above. I hereby authorize Warren's Drug Store to bill Medicare Part B/Part D or my private insurance plan on my behalf. I request that payment of authorized benefits, including administration, be made to Warren's Drug Store for the COVID-19 vaccine.

I understand that this product has not been approved or licensed by the FDA, but has been authorized for emergency use by FDA, under an EUA to prevent COVID-19 for use in individuals 18 years of age and older, and the Emergency Use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.

I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccines(s).
I acknowledge that I have been advised to remain near the vaccination location for at least 15 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.

I acknowledge that I understand the purposes/benefits and risks of this COVID-19 vaccine, that my information regarding the receipt of this COVID-19 vaccine will be entered into an immunization registry maintained by the State of North Carolina and my information will be shared with the CDC.

I have read, or have had read to me, the written information regarding the COVID-19 vaccine. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Warren's Drug Store, Inc, its affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine marked below. I acknowledge the offer of and/or receipt of Warren's Drug Store Notice of Privacy Rights and have been provided, upon request, a copy of a current Vaccine Information Sheet for the vaccine I have received today.

PATIENT SIGNATURE: _____ DATE: _____

Manufacturer: **Moderna** Dose: **0.5mls**

First Dose Site of Injection: LD RD Lot # _____ Exp Date: ___/___/_____ Date Administered: _____
Second Dose Site of Injection: LD RD Lot # _____ Exp Date: ___/___/_____ Date Administered: _____

Manufacturer: **J&J** Dose: **0.5mls** Site of Injection: LD RD Lot # _____ Exp Date: ___/___/____ Date Administered: _____

SIGNATURE OF VACCINATOR (1st Dose) _____ SIGNATURE OF VACCINATOR (2nd Dose) _____

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