Vaccination Administration Record
(Standard)

RANDY'S Family Drug and GIFT

Information about the person to receive the vaccine:

Please answer all questions. If the personal information asked for is NOT provided, the immunization service may be denied. Except as required by law, this information is confidential and will not be shared with anyone without your specific authorization.

First Name: _____ **Last Name:** _____

Date of Birth: _____

For All Vaccines: Please answer questions 1-7

1. Which vaccine(s) are you requesting to have administered today?

   □ **Influenza** □ **COVID-19** □ **Pneumonia** □ **Shingles** □ **Tdap** (Tetanus/Whooping Cough) □ **Other** _____

2. Have you received the COVID-19 vaccine before? If yes, has it been 6 months since 2nd dose? ..... □ **YES** □ **NO** □ **Unsure**
3. Are you sick or do you have a fever today? ..... □ **YES** □ **NO** □ **Unsure**
4. Do you have allergies to medicine, foods, a vaccine component or latex? ..... □ **YES** □ **NO** □ **Unsure**
5. Have you ever had a severe reaction after receiving ANY vaccine in the past? ..... □ **YES** □ **NO** □ **Unsure**
6. Are you immunocompromised or are you on medications that affect your immune system? ..... □ **YES** □ **NO** □ **Unsure**
7. Have you had a seizure, or brain or other nervous system problem such as Guillain-Barré syndrome?..... □ **YES** □ **NO** □ **Unsure**
8. For women: are you pregnant, breastfeeding or planning on becoming pregnant in the next 3 months? ..... □ **YES** □ **NO** □ **Unsure**

Consent for Vaccination: I certify that I am: the Patient and at least 19 years of age, I hereby give my consent to the health care provider of Randy's Family Drug to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects of complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) 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. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Randy's Family Drug, as applicable, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's immunization registry; (b) I have elected to participate in the Registry and consented to Randy's Family Drug to reporting my immunization information, (c) I authorize the release of my medical or other information, including my communicable disease, mental health and drug/alcohol abuse information to my health care professionals, Medicare, Medicaid, or other third party payor as necessary to effectuate care or payment; (d) submit a claim to my insurer for the above requested items and services, and (e) request payment of authorized benefits be made on my behalf to Randy's Family Drug, as applicable, with respect to the above requested items and services.

Authorization to bill: I hereby authorize Randy's Family Drug to bill Medicare or my health insurance for immunization services. I understand that the pharmacy will be reimbursed directly from Medicare or my insurance plan. I understand that I am responsible for payment of co-pays, co-insurance and any claims denied by my insurance.

Assignment of benefits and responsibilities for payment: This lets us bill your health plan or company and to receive payment directly. However, there is no out-of-pocket cost for receiving COVID-19 vaccine, either for the cost of the vaccine, or for the administration fee. I authorize Randy's Family Drug to bill my health plan or other payers on my behalf, and to receive payment of authorized benefits.

Patient Signature: _____ **Date:** _____

Consent form for 2nd dose of COVID-19 Vaccine OR Shingrix: Please answer questions 1-6

1. Are you sick or do you have a fever today? ..... □ **YES** □ **NO** □ **Unsure**
2. Do you have allergies to medicine, foods, a vaccine component or latex? ..... □ **YES** □ **NO** □ **Unsure**
3. Have you ever had a severe reaction after receiving ANY vaccine in the past? ..... □ **YES** □ **NO** □ **Unsure**
4. Are you immunocompromised or are you on medications that affect your immune system? ..... □ **YES** □ **NO** □ **Unsure**
5. Have you had a seizure, or brain or other nervous system problem such as Guillain-Barre syndrome?..... □ **YES** □ **NO** □ **Unsure**
6. For women: are you pregnant, breastfeeding or planning on becoming pregnant in the next 3 months? ..... □ **YES** □ **NO** □ **Unsure**

Patient Signature: _____ **Date:** _____

** Below Section to be filled out by the PHARMACIST **

Administered By (print): _____ Signature: _____- PharmD/ RPh

Date of Administration: _____

Vaccine	Lot #	Exp Date	Mfg	Dosage	Circle Site of Injection
				0.5 ml	L / R Deltoid IM
				0.5 ml	L / R Deltoid IM
				0.5 ml	L / R Deltoid IM

COVID-19 Vaccine Administration Record

---------- 1st Vaccine or Booster Vaccine Record ----------

** Below Section to be filled out by the PHARMACIST **

RX LABEL GOES HERE

Date of 1st Administration OR **Booster** Dose: _____/_____/_____

Vaccine: **Pfizer-BioNTech COVID-19 Vaccine**
Dose: **30mcg/0.3mL** **NDC# 59267-1000-01**
Manufacturer: **Pfizer, Inc.**

Lot #: _____ Expiration: _____/____/____

Injection Site: L / R Deltoid

Route: Intramuscular

Vaccine Information Sheet Provided

EUA Sheet On-site Version Date: 08/23/21

_____
Administered By (Print)

_____
Signature

---------- 2nd Vaccine Record Vaccine Record ----------

(3 weeks after 1st dose)

** Below Section to be filled out by PHARMACIST **

RX LABEL GOES HERE

Date of 2nd Administration: _____/_____/_____

Vaccine: **Pfizer-BioNTech COVID-19 Vaccine**
Dose: **30mcg/0.3mL** **NDC# 59267-1000-01**
Manufacturer: **Pfizer, Inc.**

Lot #: _____ Expiration: _____/____/____

Injection Site: L / R Deltoid

Route: Intramuscular

Vaccine Information Sheet Provided

EUA Sheet On-site Version Date: 08/23/2021

_____
Administered By (Print)

_____
Signature