

# COVID-19 Vaccine

Circle Dose: 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> 1<sup>st</sup> Booster  
2<sup>nd</sup> Booster



\_\_\_\_\_  
(First Name) (MI) (Last Name)  
(PLEASE PRINT)

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone(\_\_\_\_) \_\_\_\_\_ Male  Female

Birth date \_\_\_\_\_ (mm/dd/yy) Age \_\_\_\_\_  
Month Date Year

State where you were born \_\_\_\_\_

Country where you were born if not USA \_\_\_\_\_

Allergies: \_\_\_\_\_

Physician: \_\_\_\_\_

Race:  American Indian/Alaska Native  
 Asian  
 Black or African American  
 Native Hawaiian/Other Pacific Island  
 White  
 Other

Ethnicity:  Hispanic or Latino  
 Not Hispanic or Latino

The following questions will help us determine which vaccines may be given to you today. Please check the appropriate answer. If any question is not clear, please ask us to explain it. If you answer "yes" to any question, it does not mean you should not be vaccinated, it just means additional questions may be asked.

	Yes	No	Don't know		
1. Are you sick today or do you currently have a fever or infection?					
2. Have you ever received a dose of COVID-19 vaccine? • If yes, which vaccine product: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen					
3. Have you ever had a serious reaction (ex: anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or had to go to the hospital? • Was the severe allergic reaction after receiving a COVID-19 vaccine?					
4. Are you considered immunocompromised? (Please see attached form for details)					
5. COVID-19 vaccine history (can be filled in by patient or pharmacy staff)					
<b>Manufacturer:</b>	1 <sup>st</sup> dose (mm/dd/yy)	2 <sup>nd</sup> dose (mm/dd/yy)	3 <sup>rd</sup> dose (mm/dd/yy)	1 <sup>st</sup> booster (mm/dd/yy)	2 <sup>nd</sup> booster (mm/dd/yy)
Moderna					
Pfizer					
Janssen/J&J					

I certify that I am at least 18 years old and hereby give my consent to the staff of Gateway Pharmacy to administer the vaccine listed below. I have received the vaccine EUA fact sheet. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I, on behalf of myself, my heirs, executors, personal representatives, agents, successors and assigns hereby agree to release, indemnify and hold harmless Gateway Pharmacy, LLC., its agents, offices, 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 vaccines listed below. **This immunization is required be entered into the statewide immunization registry.**

I agree to wait near the vaccination location approximately 20 minutes for observation by a pharmacist.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

**For office use only:**

(X)	Vaccine name / mfg:	Lot#/Exp Date	Dose:	Administration Route: (Please Circle R or L)	Administered by: (staff Initials)
	COVID-19/Moderna NDC: 80777-0273-10		0.5ML 0.25ML	IM R / L	
	COVID-19/Moderna Bivalent		0.5ML	IM R / L	
	COVID-19/Pfizer NDC:59267-1000-01		0.3ML	IM R / L	
	COVID-19/Janssen NDC: 59676-0580-15		0.5ML	IM R / L	

EUA COVID-19 given to patient  Vaccination card filled out (R. 9/21/2022)  
 intake form verified by RPh \_\_\_\_\_ (initial)