HOMETOWN PHARMACY

Insurance Information:
Name of Insurance Company: _____
Policy ID: _____ BIN: _____
PCN: _____ Group: _____
Insurance Phone Number: _____

COVID Vaccine Administration Record (VAR)

Section 1: Patient Information

Name (First, Middle, Last)_____ Date of Birth:_____ Phone: _____

Address:_____ City:_____ ☐ Resident ☐ Healthcare Worker

County:_____Zip Code:_____ Gender: Male/Female

Race (Circle One): American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, Black/African American, White, Other, Choose Not to Disclose

Ethnicity (Circle One): Hispanic/Latino, Not Hispanic/Latino, Choose Not to Disclose

Section 5: (For Office Use Only)

Immunizer Signature:_____

Date Immunization and Fact Sheet Provided:_____

COVID Vaccination Card and v-safe Info Provided: ☐ Yes

Section 2: Immunization Questionnaire (Please Select Yes or No)

	Date:	Date:
1. Within the last 14 days, has the person to be vaccinated felt ill with fever, cough, or shortness of breath; or tested positive for COVID-19 (including antibody tests) or had recent exposure to someone who tested positive?	**Yes No**	**Yes No**
2. Have you ever received a dose of COVID-19 vaccine? If Yes, which vaccine product? □ Pfizer □ Moderna □ Another product _____	**Yes No**	**Yes No**
3. Has the person to be vaccinated today ever had a serious reaction (i.e. anaphylaxis) after receiving any vaccination? For example, a reaction for which you were treated with epinephrine, or for which you had to go to the hospital? If Yes, □ Was the severe allergic reaction after receiving a COVID-19 vaccine? □ Was the severe allergic reaction after receiving another vaccine or another injectable medication?	**Yes No**	**Yes No**
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	**Yes No**	**Yes No**
5. Have you received another vaccine in the last 14 days?	**Yes No**	**Yes No**
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	**Yes No**	**Yes No**
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? Do you have a condition that puts you at greater risk for severe illness from COVID (circle all that apply: cancer, chronic kidney disease, chronic lung disease, obesity, sickle cell disease, diabetes, other (describe): _____)	**Yes No**	**Yes No**
8. Do you have a bleeding disorder or are you taking a blood thinner?	**Yes No**	**Yes No**
9. Are you pregnant or breastfeeding?	**Yes No**	**Yes No**

Section 3: Consent for Vaccination:

I certify that I am: (i) the patient and at least 18 years of age; (ii) the parent or legal guardian of the minor Patient: or (iii) the legal guardian of the Patient. Further I hereby give my consent to the healthcare provider of HomeTown Pharmacy to administer the vaccine(s) I have requested. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccines. I understand the risks and benefits associated with the requested vaccines and have received appropriate information. I also acknowledge that I have had 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 area for 15 minutes for observation by the administering health care provider. On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless HomeTown Pharmacy, its staff, agents and employees from any all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of these vaccines. I authorize HomeTown Pharmacy to release any medical or other information to my health care professionals, Medicare, Medicaid, or other third party payer necessary to effectuate care or payment and request that payment of authorized benefits be made to HomeTown Pharmacy with respect to the vaccine(s) received.

Signature:_____ **Date:**_____

Section 4: Vaccine Information (Pharmacy Use Only)

Vaccine (Dose #)	Manufacturer	Lot #/Expiration	Site
1.			**□Left □Arm □IM □Right □Leg □SQ**
2.			**□Left □Arm □IM □Right □Leg □SQ**