COVID-19 Vaccine Administration Record

Portola Village Pharmacy
157 Commercial St
Portola, CA 96122-9606
Phone: (530) 832-4218 Fax: (530) 832-1375

Name (Last): _____ Name (First): _____ Name (Middle): _____
Date of Birth: _____ Gender: _____ Race: _____ Ethnicity: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone Number: _____
Primary Care Physician & Phone Number: _____
Emergency Contact Name: _____ Relation: _____ Phone Number: _____
Mother's Maiden Name _____

Question	YES	NO	DON'T KNOW
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 Vaccine?			

• If you have received a dose of COVID-19 Vaccine before:
  • Vaccine manufacturer (example: Pfizer, Moderna): _____
  • Number of Previous Doses: _____			

3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• **A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures**			
• **Polysorbate**			
• **A previous dose of COVID-19 Vaccine**			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies?			
6. Have you received any vaccine in the last 14 days?			
7. Have you had a positive test for COVID-19 in the last 3 months?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? *[note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]*			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			

NAME (PRINTED) _____ **SIGNATURE** _____ **DATE** _____

****PHARMACY USE ONLY****

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	☐ 1st Dose ☐ 2nd Dose	☐ IM - L Arm ☐ IM - R Arm		☐ Moderna ☐ Pfizer			
COVID-19	☐ 1st Dose ☐ 2nd Dose	☐ IM - L Arm ☐ IM - R Arm		☐ Moderna ☐ Pfizer			

Pharmacist Signature: _____ **NCIR**: _____ **Scanned RX**: _____ **PCP Notify:** _____