giant eagle pharmacy

Immunization Administration Record

COVID-19 Vaccine

First Name:	Last Name:	Sex assigned at birth: □ Male □ Female
Address:	City: State:	Zip:
Phone:	Social Security Number:	
Birthdate:	Age: Weight(Lb):	Insurance:
Primary Care Physician (PCP) First Name:	PCP Last Name:	
PCP Address:		
PCP Phone:	PCP Fax:	

For Clinics Only:	Insurance:	Group:	ID #:
	Insurance:	Group:	ID #:
	GEAC #: 4		□ GEAC Scanned □ Look up GEAC

	Please check "yes" or "no" for each question	**Yes**	**No**	**Notes**
1.	**Are you 18 years of age or older?**	☐	☐	**Age:**
2.	**Have you previously received a dose of COVID vaccine?** If so, how many doses? When was your last dose? What COVID vaccine are you requesting today?	☐	☐	
3.	**Do you have a weakened immune system or taking medication that affects your immune system?** By answering yes, you attest to meeting the current requirements of the Centers for Disease Control and Prevention (CDC) for immunocompromised patients.	☐	☐	
4.	Are you feeling sick today?	☐	☐	
5.	In the past 10 days, have you been in contact with someone who has confirmed or suspected COVID-19?	☐	☐	
6.	In the past 10 days, have you had a positive test or doctor's diagnosis for COVID-19?	☐	☐	
7.	In the past 90 days, have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?	☐	☐	
8.	Have you ever had an allergic reaction to a COVID-19 vaccine component (Polyethylene glycol or PEG; POLYSORBATE; SIMETHICONE), or to a previous dose of a COVID-19 vaccine?	☐	☐	
9.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	
10.	Do you have a history of myocarditis or pericarditis?	☐	☐	
11.	Have you received the monkeypox vaccine in the last 4 weeks?	☐	☐	
12.	Have you received a hematopoietic cell transplant (HCT) or CAR-T-cell therapy since receiving vaccine, or did you receive vaccine while being treated with rituximab or ocrelizumab?	☐	☐	
13.	For women: Are you pregnant or nursing?	☐	☐	

Please note: There is a risk of myocarditis/pericarditis after Moderna, Pfizer, or Novavax vaccination.

Consent for services, medical records, and HIPAA privacy information

Medicare/Medigap Policy Holders: I request and assign payment of authorized Medicare and/or Medigap benefits, as applicable, to be made on my behalf to Giant Eagle Pharmacy for any products or services furnished by them to me. I authorize the release of medical information about me to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents as necessary to determine benefits payable for these or related services.

All Patients: I acknowledge receipt of Giant Eagle's Notice of Privacy Practices and authorize the release of immunization information to Federal and state authorities and to any covering health insurance provider(s). For the vaccine(s) indicated hereon, I acknowledge receipt of the relevant Vaccine Information Sheet (VIS) or EUA Fact Sheet. I affirm that I have had the opportunity to ask questions and that I voluntarily assume full responsibility for any reactions that may result. I request administration of the immunization(s) to me or to the patient identified hereon for whom I am the legal guardian. I, for myself, my wards, heirs, executors, personal representatives and assigns, hereby release Giant Eagle, Inc., the hosting facility and its managing and operating companies and owners, the event sponsors, and each entity's respective affiliates, subsidiaries, divisions, directors, contractors, agents and employees, from any and all claims arising out of, in connection with, or in any way related to, the receipt or administration of the immunization(s) indicated hereon. Further, I affirm that I request and access these services at my own risk and will not hold the aforementioned parties, to any extent whatsoever, liable, responsible, or in any way accountable for any loss, physical or personal injury, death, or damages suffered or sustained at any time in connection with or as a result of their offering of this vaccine program, the administration or receipt of the vaccines requested, or access to or use of the hosting facilities.

Signature (Patient or Parent/Legal Guardian): _____Date:_____

Print Full Legal Name (Patient or Parent/Legal Guardian): _____

For School Clinics Only: My signature above indicates that I understand that if this release is executed in support of a school-sponsored immunization program, I consent to the person named above, for whom I am a parent or legal guardian, receiving the applicable immunization without me being present on the clinic date of : _____.

Revised 10.10.23 CG

Giant Eagle Pharmacy Use Only

Patient Name:	DOB:

By signing below, I agree that as the immunizing healthcare professional:

- ☐ I reviewed the patient's information and screening question responses.
- ☐ This vaccine is appropriate for this patient based on the responses to the screening questions and age guidelines according to ACIP recommendations, Giant Eagle's current vaccine protocols, and state or federal regulations.
- ☐ Appropriate written education has been provided to the patient, including a Well Child Visit Reminder as applicable.

Signature (Immunizer):_____ Date: _____

Print Name (Immunizer):_____Title (Immunizer): _____

If Pharmacy Intern or Technician, overseeing Pharmacist to sign and print name: _____

If using PREP Act, Ordering Pharmacist name and signature: _____

Ordering Pharmacist NPI:_____ Ordering Pharmacist License #:_____

If using Immunization Protocol, Ordering Physician name:_____

COVID-19 Vaccine		
Patients 3-4 years of age		
☐ Moderna COVID-19 Vaccine (23-24 Formula) **(25mcg/0.25mL)** NDC: 80777-**0287**-92 (SDV)	☐ **Dose 1** ☐ **Dose 2** ☐ **Dose 3** ☐ **Booster**	Lot Number: Expiration Date:
Sig: Administer 1 shot intramuscularly into the:	☐ **Left Deltoid** ☐ **Right Deltoid**	No Refills
Patients 5-11 years of age		
☐ Pfizer COVID-19 Vaccine (23-24 Formula) **(10mcg/0.3 mL)** NDC: 59267-**4331**-02 (SDV)	☐ **Dose 1** ☐ **Dose 2** ☐ **Dose 3** ☐ **Booster**	Lot Number: Expiration Date:
Sig: Administer 1 shot intramuscularly into the:	☐ **Left Deltoid** ☐ **Right Deltoid**	No Refills
☐ Moderna COVID-19 Vaccine (23-24 Formula) **(25mcg/0.25mL)** NDC: 80777-**0287**-92 (SDV)	☐ **Dose 1** ☐ **Dose 2** ☐ **Dose 3** ☐ **Booster**	Lot Number: Expiration Date:
Sig: Administer 1 shot intramuscularly into the:	☐ **Left Deltoid** ☐ **Right Deltoid**	No Refills
Patients 12+ years of age		
☐ Comirnaty COVID-19 Vaccine (23-24 Formula) Mfgr: Pfizer **(30mcg/0.3 mL)** NDC: 00069-**2392**-10 (PFS); 00069-**2362**-10 (SDV)	☐ **Dose 1** ☐ **Dose 2** ☐ **Dose 3** ☐ **Booster**	Lot Number: Expiration Date: VIS Date:
Sig: Administer 1 shot intramuscularly into the:	☐ **Left Deltoid** ☐ **Right Deltoid**	No Refills
☐ Spikevax COVID-19 Vaccine (23-24 Formula) Mfgr: Moderna **(50mcg/0.5mL)** NDC: 80777-**0102**-96 (PFS); 80777-**0102**-93 (PFS); 80777-**0102**-95 (SDV)	☐ **Dose 1** ☐ **Dose 2** ☐ **Dose 3** ☐ **Booster**	Lot Number: Expiration Date: VIS date:
Sig: Administer 1 shot intramuscularly into the:	☐ **Left Deltoid** ☐ **Right Deltoid**	No Refills
☐ Novavax COVID-19 Vaccine (23-24 Formula) **(5mcg/0.5mL)** NDC: 80631-**0105**-02 (MDV)	☐ **Dose 1** ☐ **Dose 2** ☐ **Booster**	Lot Number: Expiration Date:
Sig: Administer 1 shot intramuscularly into the:	☐ **Left Deltoid** ☐ **Right Deltoid**	No Refills