

# COVID Vaccine Administration Record (VAR)

## Section 1: Patient Information

Place Rx Label Here  
(Pharmacy Use Only)

Name (First, Middle, Last) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Gender: Male/Female Social Security Number: \_\_\_\_\_ **Section 5: (For Office Use Only)**

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

**Immunizer Signature:** \_\_\_\_\_

**Date Immunization and Fact Sheet Provided:** \_\_\_\_\_

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

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

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

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
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"/> Another product	Yes	No
3. Has the person to be vaccinated today ever had a serious reaction (i.e. anaphylaxis) after receiving any vaccination/food/product? For example, a reaction for which you were treated with epinephrine, or for which you had to go to the hospital? If Yes, <input type="checkbox"/> Was the severe allergic reaction after receiving a COVID-19 vaccine? <input type="checkbox"/> Was the severe allergic reaction after receiving another vaccine or another injectable medication?	Yes	No
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	Yes	No
5. Have you received another vaccine in the last 14 days?	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
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
8. Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No
9. Are you pregnant or breastfeeding?	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.			<input type="checkbox"/> Left <input type="checkbox"/> Arm <input type="checkbox"/> IM <input type="checkbox"/> Right <input type="checkbox"/> Leg <input type="checkbox"/> SQ
2.			<input type="checkbox"/> Left <input type="checkbox"/> Arm <input type="checkbox"/> IM <input type="checkbox"/> Right <input type="checkbox"/> Leg <input type="checkbox"/> SQ