giant eagle pharmacy

Pennsylvania Immunization Administration Record for Clinics

COVID-19 Vaccine

BRING ID, Medicare B Card, Medical Ins Card, and RX Ins Card

First Name:	Last Name:		□ M □ F
Address:	City:	State:	Zip:
Phone:	Social Security Number:		
Birthdate:	Age: (YRS)	Weight:	(LB)
Race: □ American Indian or Alaska Native	□ Asian		□ Black or African American
□ Hawaiian or Other Pacific Islander	□ White		□ Unknown/Not Reported
Ethnicity: □ Hispanic or Latino	□ Not Hispanic or Latino		□ Unknown/Not Reported
Primary Care Physician (PCP) First Name:	PCP Last Name:		
PCP Address:			
PCP Phone:	PCP Fax:		

	Indications: *Please check "yes" or "no" for each question.*	**Yes**	**No**	**Notes**
1.	Are you 16 years of age or older?			
2.	Have you previously received a dose of COVID vaccine? What product? When? Product: Date received:			
	Precautions and Contraindications: *Please check "yes" or "no" for each question.*	**Yes**	**No**	**Notes**
3.	Are you sick today? *Record patient temperature*			Temp:
4.	In the past month, have you been in contact with someone who has confirmed or suspected Coronavirus/COVID-19?			
5.	Over the last 14 days, have you had any of the following symptoms: cough, fever, loss of smell or taste, shortness of breath, or chills?			
6.	Have you had a positive test or doctor's diagnosis for COVID-19?			
7.	Have you received plasma or monoclonal antibodies for COVID in the past 90 days?			
8.	Have you received any vaccinations in the past 14 days?			
9.	Do you have allergies to food, medications, a vaccine component (PEG, POLYSORBATE), or latex?			
10.	Have you ever had a severe allergic reaction to something?			
11.	Do you have a bleeding disorder or are you taking a blood thinner?			
12.	Are you immunocompromised (have a weakened immune system) or are you taking medication that affects your immune system?			
13.	For women: Are you pregnant or nursing?			

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 Legal Guardian): _____ Date: _____

Print Full Legal Name: _____

Reviewed: 2/24/21 CG

Pennsylvania Immunization Administration Record for Clinics

COVID-19 Vaccine

BRING ID, Medicare B Card, Medical Ins Card, and RX Ins Card

Giant Eagle Pharmacy Use Only

Patient Name:	DOB:

□ Verbally confirmed patient meets the eligibility requirements for the current phase of vaccination.

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 regulations.

Signature (Immunizer):_____ Date:_____

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

If Pharmacy Intern, print name of overseeing Pharmacist: _____

Vaccine: Pfizer BioNTech COVID-19 Vaccine (0.3 mL) IM Dose:_____	**Lot Number:**
Giant Eagle Immunization Clinic-Downtown Pittsburgh	**Expiration Date:**
Sig: Administer 1 shot intramuscularly into the: □ Left Deltoid □ Right Deltoid	**Ordering Provider: Dr. Shaun D. Gill**
	No Refills

Medicare B Insurance	**Name as it appears on card:**	**ID#:**
Medical Insurance:	**Group#:**	**ID#:**
Prescription Insurance:	**Group#:**	**ID#:**