Vaccine Administration Record

Willow Creek Pharmacy
1700 S Main St, Lamar CO 81052
719 336-3200

Name: _____ Male: _____ Female: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Primary Care Physician Name and Address: _____

Allergies: _____ Medicare # (including letters): _____

Ethnicity (optional): Caucasian_____ African American_____ Hispanic_____ Asian_____ American Indian_____ Other_____

Screening Questions

1. Are you sick today?	YES	NO
2. Do you have any allergies to medications, foods, latex? If yes, please list_____	YES	NO
3. Have you ever had a serious reaction to a previous dose of vaccine or any medication?	YES	NO
4. Have you had a severe allergic reaction to anything?	YES	NO
5. Have you ever had a severe allergic reaction to any component of the COVID-19 vaccine?	YES	NO
6. Are you pregnant or breastfeeding, or is there a chance you could become pregnant in the next 14 days?	YES	NO
7. Have you received any vaccinations in the past 14 days?	YES	NO
8. Have you been ill or recovered from a COVID infection or had antibody therapy in the last 3 months?	YES	NO
9. Do you have any of the following illnesses or conditions? Chronic lung disease (including asthma), heart disease, diabetes, brain , spinal cord, or muscle illness that causes swallowing or lung problems, problems with the immune system caused by medications and/or HIV, kidney disease, liver disease, blood disorders	YES	NO
10. Have you had a COVID vaccine before? Which Vaccine? _____Moderna _____Pfizer_____(other)	YES	NO

11. Please identify which Phase Category you are in:

☐ Phase 1A - Highest Risk: Direct contact with COVID Patients, LTC staff/residents

☐ Phase 1B - Moderate Risk: Coloradans age 70+, moderate-risk health care workers, first responders, frontline essential workers, and continuity of state government

☐ Phase 2 - Higher-risk individuals: Age 60-69, others with underlying health conditions, other essential workers

☐ Phase 3 - General Public: Age 18-64 without high-risk conditions

I have received a Notice of Privacy Practice for HIPAA. I have read, or have had read to me, the EUA information for the COVID vaccine I am receiving I have been able to ask questions about the vaccine, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine. I consent to the administration of the vaccine requested. I understand that the vaccination information will be shared with the state immunization database. I agree to stay in the general area for 15-30 minutes after receiving my vaccination in case any immediate reactions occur. If I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); the subsidiaries and affiliates of the pharmacy; the respective directors, officers, employees, and agents of the pharmacy and its subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination.

Name (print)_____ Signature_____ Date_____

PHARMACY USE ONLY

_____ LD or RD

Signature of vaccine administrator Site of Injection

By signing as administrator you are confirming that contraindications and side effects have been reviewed and a current VIS was provided to the patient receiving the vaccine.

☐ Billing