ZIKS Family Pharmacy
Home Medical Equipment & Wellness Center

COVID-19 VACCINE ADMINISTRATION RECORD

ZIKS FAMILY PHARMACY
1130 West Third Street
Dayton, OH 45402
Office: 937.225.9350
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PART 1: *Please print clearly*

First Name:	Middle Init:	Last Name:		Age:
Home Phone: (_ _ _) _ _ _ - _ _ _ _	Gender: (M/F)	Weight:	Date of Birth: _ _ / _ _ / _ _ _ _	County:
Home Address:		City:	State:	Zip Code:
Primary Care Physician/Provider Name:		Physician/Provider Tel: (_ _ _) _ _ _ - _ _ _ _		

I WANT TO BE PROTECTED FROM THE FOLLOWING (*PLEASE CHECK ALL THAT APPLY*):

☐ COVID-19

PART 2: Please answer the following questions so we can assess the safety and appropriateness of the vaccination	**Yes**	**No**
1. Do you have a fever or illness today?		
2. Do you have any severe allergies to medications, foods (e.g. eggs), latex or a vaccine component (e.g. gelatin, neomycin, polymyxin, yeast, thimerosal, etc.)? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital? if Yes, please list what you are allergic to: _____		
3. Have you ever had a serious reaction after receiving a vaccine? (Lip swelling, arm swelling, trouble breathing, seizure, etc.)		
a. Was the severe allergic reaction after receiving a COVID-19 vaccine?		
b. Was the severe allergic reaction after receiving another vaccine or another injectable medication?		
4. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Another product: _____		
5. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		
6. Do you have a bleeding disorder or are you taking a blood thinner?		
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?		
8. Have you received passive antibody therapy as treatment for COVID-19?		
9. Have you experience seizures, Guillain-Barre Syndrome, or any other neurological disorder?		
10. Have you received any vaccines in the last 14 days? if Yes, please list the vaccine and date: _____		
11. Have you had a mastectomy? ** If yes, ☐ Left ☐ Right ☐ Both		
12. For women: Are you currently pregnant, breastfeeding, or are you planning to become pregnant in the next month?		

PART III I hereby give my consent to the healthcare provider ZIKS Family Pharmacy, to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the vaccine(s) being administered and have received, read and/or had explained to me the CDC's Vaccine Information Statement (VIS) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. I fully release and hold harmless ZIKS Family Pharmacy, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all liabilities or claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I understand that the information contained on this form may be shared with the Stated Health Division (SHD) and/or state immunization registries and will remain confidential and will not be released except as permitted or required by law. If eligible, I authorize ZIKS to submit a claim for reimbursement on my behalf to Medicare or any other contracted third-party payor. If the claim is denied, I understand that I will be responsible for payment. Furthermore, I acknowledge that I have been advised to remain near the vaccination location for approximately 15-20 minutes after administration for observation by the administering healthcare provider.

Patient/POA Signature*: _____ **Date:** _____
(*or Signature of Legal Guardian if patient is under age 18)

Form completed by _____ **Date:** _____

Form reviewed by _____ **Date:** _____

Check one: ____Individual* ____Staff* ____Independent Provider ____Family Member / Caregiver
*Please add the name of the provider below

Provider Name: _____

PLEASE INCLUDE POWER OF ATTORNEY DOCUMENTATION AND COPY OF ALL INSURANCE CARDS

PART IV (For Pharmacy Use Only) *The following section is to be completed by the pharmacy:*

Vaccine Name: _____	Injection Site Arm: LEFT RIGHT
Manufacturer: _____	Route: IM SubQ
Dose: 0.3mL 0.5mL 0.65mL 1.0mL	Immunizer: _____ RPh/Intern
Vaccine Lot #: _____	Supervising RPh/License#: _____
Vaccine Exp. Date: _____	Date Administered/VIS Given: ____/____/____
Diluent Lot #/Exp. Date: _____	VIS Version Date: ____/____/____

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