Site
Name _____
Address _____
_____

NORD'S PHARMACY & GIFTS

VACCINE ADMINISTRATION RECORD
2020/2021 *SARS-CoV-2* (COVID-19) Vaccine

BILLING INFO:

_____ Private Insurance _____ MA _____ Uninsured

Information about person to receive vaccine (PLEASE PRINT)

Name: Last	First	Middle Initial ☐ Male ☐ Female	Phone

Birthdate	Age	Address	City / State	County	Zip

1. Are you sick today or in isolation for COVID-19?	☐ YES	☐ NO
2. Are you currently in quarantine for COVID-19 exposure? (known exposure in the past 14 days)	☐ YES	☐ NO
3. Have you ever had a severe allergic reaction to a COVID-19 vaccine, any other vaccine, or injectable therapy?	☐ YES	☐ NO
4. Have you received any vaccinations in the past 14 days? If yes, vaccine received_____ Date _____	☐ YES	☐ NO
5. Have you received monoclonal antibodies or convalescent plasma for COVID-19 treatment in the past 90 days?	☐ YES	☐ NO
6. Are you breastfeeding, pregnant, or planning to become pregnant in the next month?	☐ YES	☐ NO
7. Do you have HIV, take immunosuppressive medications, or have another immunocompromising condition?	☐ YES	☐ NO
8. Have you received a previous dose of a COVID-19 vaccine? If so, _____ Pfizer-BioNtech or ____ Moderna Date of 1st dose: _____	☐ YES	☐ NO
9. Do you have a chronic medical condition? If so, please indicate:_____	☐ YES	☐ NO
10. Are you 16 years of age or older (Pfizer-BioNtech) and/or 18 years or older (Moderna)? Please indicate.	☐ YES	☐ NO

Immunization information may be shared through the Minnesota Immunization Information Connection (MIIC) with other healthcare providers, schools, health departments, and others authorized under law to receive it. If you have any questions, please ask your health care provider. If you decide not to have this information shared with MIIC, please call 1-800-657-3970.

Assignment of Benefits and Responsibilities for Payment: *(This allows us to bill your health plan or company and receive payment directly. It also means that you agree to pay for services not covered by your health plan.) I authorize this health provider to bill my health plan or other payers on my behalf, and to receive direct payment of authorized benefits. I agree that it is my responsibility to pay for any health care services not covered by my health plan or company, including but not limited to copayments, deductibles, and co-insurance.*

Agreement: *I have read or had explained to me the Emergency Use Authorization I have had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the SARS-CoV-2 (COVID-19) vaccination be given to me or to the person named above for whom I am authorized to make this request. I also acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.*

SIGNATURE: X **DATE:** _____

(person to receive vaccine or legal guardian)

For Clinic/Office Use

Vaccine	*Group*	*Manufacturer*	***Lot #***	***Site***	*Route*	***EUA***
SARS-CoV-2 (COVID-19)	**0.5mL** **0.3mL**	**Moderna** **Pfizer-BioNtech**		LA RA LT RT	IM	12/2020

Signature and Title of Person Administering Vaccine:	**Date vaccine and EUA given:**