



COVID-19 Immunization Record

Last Name	First Name	Initial	Sex
Provincial Health Care Number		Date of Birth (yyyy-Mon-dd)	
Address		Phone (Home)	
City	Postal Code	Phone (Other)	

Please answer the following:

1. Do you have any of the following symptoms?

- | | | |
|---|---|--|
| • Fever <input type="checkbox"/> yes <input type="checkbox"/> no | • Runny nose <input type="checkbox"/> yes <input type="checkbox"/> no | • Painful swallowing <input type="checkbox"/> yes <input type="checkbox"/> no |
| • Cough <input type="checkbox"/> yes <input type="checkbox"/> no | • Sore throat <input type="checkbox"/> yes <input type="checkbox"/> no | • Shortness of breath <input type="checkbox"/> yes <input type="checkbox"/> no |
| • Chills <input type="checkbox"/> yes <input type="checkbox"/> no | • Nasal congestion <input type="checkbox"/> yes <input type="checkbox"/> no | • Loss of taste/smell <input type="checkbox"/> yes <input type="checkbox"/> no |
| • Fatigue <input type="checkbox"/> yes <input type="checkbox"/> no | • Loss of appetite <input type="checkbox"/> yes <input type="checkbox"/> no | • Nausea/vomiting/diarrhea <input type="checkbox"/> yes <input type="checkbox"/> no |
| • Headache <input type="checkbox"/> yes <input type="checkbox"/> no | • Muscle/joint aches <input type="checkbox"/> yes <input type="checkbox"/> no | • Conjunctivitis (pink eye) <input type="checkbox"/> yes <input type="checkbox"/> no |

2. Have you tested positive for COVID-19 in the past 90 days? yes no

3. If you answered yes to #2, did you receive medication to treat your COVID-19 infection? yes no

****IF YOUR ANSWER TO AN ABOVE QUESTION IS YES, YOU MAY NEED TO RESCHEDULE****

4. Do you have any allergies? yes no If yes, please list:

5. Have you ever had a serious reaction to a vaccine? yes no

6. Do you have any autoimmune conditions, or do you take immunosuppressive medications? yes no

7. Have you had a COVID-19 vaccine in the past? yes no

8. Have you had any other vaccines in the past 14 days? yes no

9. Women: Are you pregnant or breastfeeding? yes no

- I understand that the pharmacist has received appropriate training and is registered to administer injections by the Alberta College of Pharmacists. I understand the pharmacist will comply with all professional standards surrounding the administration of injections as well as general pharmacy practice. The pharmacist maintains current certification in CPR and Basic First Aid.
- I agree to remain at the location for 15-30 minutes after the injection as directed by the pharmacist.
- The pharmacist has provided me with information on the vaccine being administered and the injection procedure so that I understand the expected outcome/reaction, as well as possible side effects.
- In the event of an emergency, I authorize the pharmacist to administer epinephrine and/or apply necessary lifesaving procedures as an interim measure until medical support personnel arrive.
- In case of emergency please contact emergency services at 911.
- I have read and understand the above information.

Patient signature (parent or guardian if minor)

COVID-19 Vaccine (pharmacist use only)	
<input checked="" type="checkbox"/> Informed consent <input type="checkbox"/> Netcare checked for previous vaccination Brand(of previous vaccination: _____ Date of previous vaccination: _____ Time of first vial puncture: _____ Date vaccine given _____ Time of administration _____	Vaccine (Manufacturer): <input type="checkbox"/> Moderna 0.5 mL IM Lot 009L21A Exp 08/22 <input type="checkbox"/> Pfizer/BioNTech 0.3mL IM Lot FT8471 Exp 11/22 <input type="checkbox"/> Moderna 0.25mL IM Lot 009L21A Exp 08/22 Site: Deltoid <input type="checkbox"/> Left <input type="checkbox"/> Right Dose: <input type="checkbox"/> 1 of 2 <input type="checkbox"/> 2 of 2 <input type="checkbox"/> 3rd dose <input type="checkbox"/> 4th dose
Pharmacist's Name (printed)	Pharmacist's Signature