# 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 ☐ yes ☐ no | • Runny nose ☐ yes ☐ no | • Painful swallowing ☐ yes ☐ no |
| • Cough ☐ yes ☐ no | • Sore throat ☐ yes ☐ no | • Shortness of breath ☐ yes ☐ no |
| • Chills ☐ yes ☐ no | • Nasal congestion ☐ yes ☐ no | • Loss of taste/smell ☐ yes ☐ no |
| • Fatigue ☐ yes ☐ no | • Loss of appetite ☐ yes ☐ no | • Nausea/vomiting/diarrhea ☐ yes ☐ no |
| • Headache ☐ yes ☐ no | • Muscle/joint aches ☐ yes ☐ no | • Conjunctivitis (pink eye) ☐ yes ☐ 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)** | |
|---|---|
| ☑ Informed consent<br>☐ Netcare checked for previous vaccination<br>Brand of previous vaccination: _____<br>Date of previous vaccination: _____<br>Time of first vial puncture: _____<br>Date vaccine given _____<br>Time of administration _____ | Vaccine (Manufacturer):<br>☐Moderna 0.5 mL IM Lot 016L21A Exp 06/22<br>☐Pfizer/BioNTech 0.3mL IM Lot FT8471 Exp 08/22<br>☐Moderna 0.25mL IM Lot 016L21A Exp 06/22<br>Site: Deltoid ☐ Left ☐ Right<br>Dose: ☐ 1 of 2 ☐ 2 of 2 ☐ 3rd dose ☐ 4th dose |
| **Pharmacist's Name (printed)** | **Pharmacist's Signature** |
| | |