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 travelled outside of Canada in the past 14 days? ☐ yes ☐ no
3. Have you been in close contact with a confirmed case of COVID-19 in the past 14 days? ☐ yes ☐ no

****IF YOUR ANSWER TO ANY OF THE ABOVE QUESTIONS IS YES, YOU MUST 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 ☐ 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): ☐Moderna 0.5 mL IM Lot 093D21A Exp 12/21 ☐Pfizer/BioNTech 0.3mL IM Lot FF2595 Exp 03/22 ☐AstraZeneca 0.5 mL IM ☐Johnson & Johnson 0.5 mL IM Site: Deltoid ☐ Left ☐ Right Dose: ☐ 1 of 2 ☐ 2 of 2
Pharmacist's Name (printed)	**Pharmacist's Signature**