



DUNCANSVILLE PHARMACY

1328 3rd Avenue Duncansville, PA 16635
814-695-8065

PLEASE PRINT CLEARLY

PATIENT INFORMATION FOR PFIZER VACCINE

PATIENT NAME: (Last)		(First)	(MI)
GENDER: M / F / Self-Identify		DATE OF BIRTH: (MM/DD/YYYY)	
ADDRESS:			
CITY:		STATE:	ZIP CODE:
CELL PHONE NUMBER:	IF NO CELL, LANDLINE:	EMAIL:	
RACE: (Circle one) White Asian Black/African American Hispanic Other			
Is this the patient's first or second dose of the COVID-19 vaccination? <input type="checkbox"/> First Dose <input type="checkbox"/> Second Dose			

SCREENING QUESTIONS

DOSE 1 DOSE 2
Yes No Yes No

	DOSE 1 Yes	DOSE 1 No	DOSE 2 Yes	DOSE 2 No
1. Are you feeling sick today?				
2. Have you received passive antibody therapy as a COVID-19 treatment? (If yes, date: _____)				
3. Have you received a dose of any COVID-19 vaccine, PRIOR to this series? (If yes, which one: _____)				
4. Do you have a bleeding disorder?				
5. Do you take prescription blood thinners?				
6. In the past 14 days, have you ever tested positive for COVID-19?				
7. Have you received another vaccine in the past 14 days?				
8. Have you ever had an allergic reaction to previous vaccines, other injectables, or shellfish? (If yes, please explain: _____)				
9. Do you have a weakened immune system or take immunosuppressive drugs? (If yes, please explain: _____)				
10. Are you pregnant or breastfeeding?				
11. In the past 10 days, have you experienced: fever, chills, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?				
12. I read the current (EUA) Vaccine Information Statement for the COVID-19 vaccine and understand the benefits and risks.				

My signature below authorizes Duncansville Pharmacy to vaccinate myself with the COVID-19 vaccine. I also agree to hold harmless Duncansville Pharmacy (all officers, agents, or employees) against claims, demands, actions, suits, damages, liabilities, losses, settlements, judgements, costs, and any expenses, which may arise out of or relate to the administration of this vaccine.

*I certify that I am : (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient and confirm that the patient is at least 12 years of age; or (c) authorized consent for vaccination for the patient named above

We ask that after administration of the vaccine, you wait approximately **15** minutes to monitor any reactions that may occur.

*Signature **Dose 1**: _____ Date: _____

*Signature **Dose 2**: _____ Date: _____

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PHARMACY TO COMPLETE BELOW:

Dose 1	Arm: L or R	Date: ____/____/____	Pfizer LOT:	Exp:
Dose 2	Arm: L or R	Date: ____/____/____	Pfizer LOT:	Exp: