TAYLOR DRUG PHARMACY
Established in 1936

Taylor Drug COVID Immunization Encounter Form

Patient Name: _____ **Birth Date:** _____/_____/_____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Phone: (_____) _____-_____ **Email:** _____ **Gender:** ☐ Male ☐ Female

Race (circle): African American • American Indian • Asian • Caucasian • Hispanic • Pacific Islander • Other

Mother's Maiden Name: _____ **Drug Allergies:** _____

Health Insurance? ☐ Yes ☐ No **Utah Medicaid?** ☐ Yes ☐ No **Medicare?** ☐ Yes ☐ No

Insurance Name: _____ **ID #:** _____ **Group:** _____

Policy Holder Name: _____ **Birth date:** _____/_____/_____ **Relation to Patient:** _____

Phone Number: (_____) _____-_____ **Address:** _____

Please answer these questions concerning the person receiving immunizations today by checking the boxes	**Yes**	**No**
Are you moderately to severely sick and/or have you had a fever within the last 24 hours?	☐	☐
Do you have allergies to medications, foods, latex, or any vaccine?	☐	☐
Have you had a serious allergic reaction in the past (anaphylaxis)?	☐	☐
Have you ever had an allergic reaction (of any severity) to mRNA COVID-19 vaccine or any of its components including polyethylene glycol (PEG) or polysorbate?	☐	☐
Do you carry an Epi-Pen®?	☐	☐
Have you been diagnosed / treated for COVID disease in the last 90 days?	☐	☐
Are you a child or adolescent taking aspirin therapy?	☐	☐
If you are a female, are you pregnant or breastfeeding?	☐	☐
Have you received any vaccinations in the past 2 weeks?	☐	☐
Have you received another COVID-19 vaccine?	☐	☐
Are you under the age of 18?	☐	☐

I have been given a copy and have read or had explained to me, the information contained in the **Vaccine Information Statement(s)** about the disease(s) and vaccine(s). Any questions I had were answered to my satisfaction. I understand the benefits and risk of the vaccine(s) and request that the vaccine(s) indicated be given to me or the person for whom I am authorized to make this request. I certify that I have been offered a copy or been given the opportunity to read the **Notice of Privacy Practices**. I agree that the immunizations may be shared with schools, day care centers, health care providers, and others to verify immunization status, for public health studies, or when medically necessary. I hereby release the Taylor Drug and their employees from all claims arising from such immunizations.

By signing below, I certify that I am 18 years old or older, and that I haven't been diagnosed with COVID-19 infection within the last 90 days.

Signature: _____ Date: _____/_____/_____

If Signature **NOT** patient's, Print Name: _____ DOB:_____/_____/_____ Relation: _____

Below for pharmacy use only

Date of Vaccine: _____/_____/_____

COVID Vaccine Used	Site	Dose	Lot #
Moderna®		0.5 mL	
Pfizer®		0.3 mL	
Janssen®		0.5 mL	

Place Rx Sticker Here

Administrator's Signature: _____ Date: _____/_____/_____

Updated 03/15/2021