giant eagle pharmacy

Immunization Administration Record

Herpes Zoster (Inactivated) Vaccine
Shingrix

First Name:		Last Name:	
Birthdate:	Age:	Weight:	Sex assigned at birth: □ Male □ Female
Address:		City:	State: Zip:
Phone:		Last 4 digits of Social Security Number:	

Primary Care Physician (PCP) First Name:	PCP Last Name:
PCP Address:	
PCP Phone:	PCP Fax:

Indications: *Please check "yes" or "no" for each question.*		**Yes**	**No**	**Notes**
1.	Are you 50 years of age or older?			
2.	Are you 19-49 years of age?			
3.	Do you have a weakened immune system or are taking medication that affects your immune system?			
4.	Have you previously received the chickenpox vaccine or had chickenpox or shingles?			
5.	Have you previously received a dose of shingles vaccine? If yes, when?			
Precautions and Contraindications: *Please check "yes" or "no" for each question.*		**Yes**	**No**	**Notes**
6.	Are you sick today?			
7.	Do you have allergies to medications, food, a vaccine component, or latex?			
8.	Have you ever had a serious reaction after receiving a vaccine?			
9.	For women: Are you pregnant or nursing?			
10.	Have you ever felt dizzy or faint before, during, or after a shot?			
11.	Are you anxious about getting a shot today?			

Talk to the pharmacist before receiving this vaccine to review the above questions.

Consent for services, medical records, and HIPAA privacy information

Medicare/Medigap Policy Holders: I request and assign payment of authorized Medicare and/or Medigap benefits, as applicable, to be made on my behalf to Giant Eagle Pharmacy for any products or services furnished by them to me. I authorize the release of medical information about me to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents as necessary to determine benefits payable for these or related services.

All Patients: I acknowledge receipt of Giant Eagle's Notice of Privacy Practices and authorize the release of immunization information to Federal and state authorities and to any covering health insurance provider(s). For the vaccine(s) indicated hereon, I acknowledge receipt of the relevant Vaccine Information Sheet (VIS) or EUA Fact Sheet. I affirm that I have had the opportunity to ask questions and that I voluntarily assume full responsibility for any reactions that may result. I request administration of the immunization(s) to me or to the patient identified hereon for whom I am the legal guardian. I, for myself, my wards, heirs, executors, personal representatives and assigns, hereby release Giant Eagle, Inc., the hosting facility and its managing and operating companies and owners, the event sponsors, and each entity's respective affiliates, subsidiaries, divisions, directors, contractors, agents and employees, from any and all claims arising out of, in connection with, or in any way related to, the receipt or administration of the immunization(s) indicated hereon. Further, I affirm that I request and access these services at my own risk and will not hold the aforementioned parties, to any extent whatsoever, liable, responsible, or in any way accountable for any loss, physical or personal injury, death, or damages suffered or sustained at any time in connection with or as a result of their offering of this vaccine program, the administration or receipt of the vaccines requested, or access to or use of the hosting facilities.

Initial: _____ I agree to be responsible for payment to Giant Eagle if my insurance plan does not cover the cost of this vaccination.

Signature (Patient or Parent/Legal Guardian): _____

Print Full Legal Name (Patient or Parent/Legal Guardian): _____ Date: _____

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Healthcare Provider Only

Patient Name:	DOB:

By signing below, I agree that as the immunizing healthcare professional:
- I reviewed the patient's information and screening question responses.
- This vaccine is appropriate for this patient based on the responses to the screening questions and age guidelines according to ACIP recommendations, Giant Eagle's current vaccine protocols, and state regulations.
- Appropriate written education has been provided to the patient, including a Well Child Visit Reminder as applicable.

Signature (Immunizer):_____ Date: _____

Print Name (Immunizer):_____Title (Immunizer): _____

If Pharmacy Intern or Technician, overseeing Pharmacist to sign and print name: _____

If using Immunization Protocol, Ordering Physician name:_____

Vaccine: Shingrix (0.5 mL) IM **Mfgr: GSK** **Dose:_____**	**Lot Number:**
	Expiration Date:
	VIS Date:
Sig: Administer 1 shot intramuscularly into the: □ Left Deltoid □ Right Deltoid	**No Refills**

Screening Questions Reference

Question	Response	Guidance **Depending on federal and/or state specific guidelines**
1.	Yes	**Patients 50+ years of age who are immunocompetent:** Administer 2 doses, separated by 2-6 months (minimum interval is 4 weeks). The second dose may be administered if more than 6 months have elapsed since the first dose. The vaccine series need not be restarted. See below for immunocompromised patients.
2.	Yes	**Patients 19-49 years of age who are or who will be immunocompromised** are indicated to receive vaccine.
3.	Yes	**Patients 19+ years of age who are or who will be immunocompromised:** Administer 2 doses, separated by 2-6 months. Dose 2 can be administered 1-2 months after the first to patients who may benefit from a shorter vaccination schedule. When possible, patients should be vaccinated before becoming Immunosuppressed. Otherwise, consider timing vaccination when the immune response is likely to be most robust (i.e., during periods of lower immunosuppression and stable disease). • Autologous HCT: Administer RZV at least 3–12 months after transplantation, preferably 2 months prior to discontinuation of antiviral therapy • Allogeneic HCT: Administer RZV at least 6–12 months after transplantation, preferably 2 months prior to discontinuation of antiviral therapy • Renal or other solid organ transplant (SOT) recipients: If vaccination prior to transplantation is not possible, administer RZV at least 6–12 months after transplantation For patients receiving anti-B cell therapies (e.g., rituximab), administer a dose of RZV approximately 4 weeks prior to the next scheduled therapy.
4.	No	Immunocompetent patients over the age of 50 years do not need to be screened for prior varicella or herpes zoster disease, varicella vaccination, or varicella immunity. Most patients born before 1980 are considered to have been exposed to varicella, are at risk for herpes zoster, and can receive Shingrix. Immunocompromised patients should be screened for prior varicella or herpes zoster disease, varicella vaccination, or varicella immunity. Immunocompromised patients who have neither experienced varicella or herpes zoster infection, nor received varicella vaccine, or have laboratory evidence of immunity, should follow the ACIP varicella vaccine recommendations for further guidance. If a patient recently received varicella vaccine, wait a minimum of 8 weeks to give Shingrix.
5.	Yes	Complete the series according to the guidance above. If it has been more than 6 months since the first dose, the second dose may be administered. The vaccine series need not be restarted.
6.	Yes	As a precaution with moderate or severe acute illness, defer vaccine until the illness has improved. Mild illnesses are NOT contraindications to vaccination. Do not defer vaccination if a person is taking antibiotics. Evaluate any reported symptoms that may be due to SARS-CoV-2 infection. Vaccination of persons with current SARS-CoV-2 infection should be deferred until the person has recovered from acute illness and they can discontinue isolation.
7.	Yes	DO NOT administer the vaccine to patients with a severe allergic reaction to any component of the vaccine, or after a previous dose of the vaccine. Check supplies if latex allergy.
8.	Yes	Gather information from patient on any serious reactions that occurred following previous vaccinations to determine if the patient should receive this vaccine.
9.	Yes	**Pregnancy:** There is no available human data to establish whether there is a vaccine-associated risk in pregnant women. Consider delaying Shingrix vaccination until after pregnancy. **Lactation:** Data to assess the effects of the vaccine on the breastfed infant or on milk production/excretion is not known. However, recombinant vaccines such as RZV pose no known risk to mothers who are breastfeeding or to their infants. Clinicians may consider vaccination without regard to breastfeeding status if RZV is otherwise indicated.
10./11.	Yes	Employ strategies to avoid the risk of injury due to dizziness or fainting, and to help the patient's anxiety.