giant eagle pharmacy

Immunization Administration Record

Respiratory Syncytial Virus Vaccine (RSV)
Abrysvo or Arexvy

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 60 years of age or older?			
2.	For women: Are you 32 to 36 weeks pregnant?			
3.	Have you previously received a dose of RSV vaccine? If yes, when?			
Precautions and Contraindications: *Please check "yes" or "no" for each question.*		**Yes**	**No**	**Notes**
4.	Are you sick today?			
5.	Do you have allergies to medications, food, a vaccine component (EX: POLYSORBATE 80), or latex?			
6.	Have you ever had a serious reaction after receiving a vaccine?			
7.	For women: Are you nursing?			
8.	Have you ever felt dizzy or faint before, during, or after a shot?			
9.	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: □ Abrysvo (0.5 mL) I.M. Mfgr: Pfizer	**Lot Number:**
□ Arexvy (0.5 mL) I.M. Mfgr: GlaxoSmithKline	**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 60-74 years of age who have not previously received a dose of RSV vaccine and who are at increased risk of severe RSV disease:** Administer one dose of RSV vaccine Patients at increased risk of RSV include: ○ Chronic cardiovascular disease ○ Chronic lung disease ○ Chronic kidney disease, advanced ○ Diabetes mellitus with end organ damage ○ Severe obesity ○ Immunocompromising conditions ○ Neurologic or neuromuscular conditions ○ Liver disorders ○ Hematologic conditions ○ Frailty ○ Residence in a nursing home or LTC facility ○ Other chronic medical conditions or risk factors that a HCP determines would increase the risk of severe disease • **Patients 75+ years of age who have not previously received a dose of RSV vaccine:** Administer one dose of RSV vaccine
2.	Yes	**Administer one dose of ABRYSVO to patients who are pregnant** (32 weeks and zero days'–36 weeks and 6 days' gestation) and who have not previously received a dose of vaccine, using seasonal administration.
3.	Yes	No further doses of RSV vaccine are recommended at this time.
4.	Yes	As a precaution with moderate or severe acute illness, all vaccines should be deferred 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.
5.	Yes	DO NOT administer the vaccine to patients with history of a severe allergic reaction (e.g., anaphylaxis) to any component of the vaccine, including POLYSORBATE 80. Check supplies if latex allergy.
6.	Yes	Gather information from patient on any serious reactions that occurred following previous vaccinations.
7.	Yes	It is not known whether ABRYSVO is excreted in human milk. Data are not available to assess the effects of ABRYSVO on the breastfed infant or on milk production/excretion.
8./9.	Yes	Employ strategies to avoid the risk of injury due to dizziness or fainting, and to help the patient's anxiety.