giant eagle pharmacy

Immunization Administration Record

Pneumococcal Vaccine

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:	
Insurance:	Group:	ID #:	

	Please check "yes" or "no" for each question	**Yes**	**No**	**Notes**
1a.	Have you previously received a dose of pneumonia vaccine?	◉	○	
1b.	If so, please list the name of the vaccine you received and when you received it:			
2.	Do you have any of the following: a long-term health problem with heart, lung, kidney, liver, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak?	○	◉	
3.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	○	○	
4.	In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had an organ transplant or radiation treatments?	○	○	
5.	Are you sick today?	○	○	
6.	Do you have allergies to medications, food (Ex: yeast, bovine milk protein), a vaccine component (Ex: diphtheria toxoid, polysorbate), or latex?	○	○	
7.	Have you ever had a serious reaction after receiving a vaccine?	○	○	
8.	Have you ever felt dizzy or faint before, during, or after a shot?	○	○	
9.	Are you anxious about getting a shot today?	○	○	
10.	Are you pregnant or nursing?	○	○	

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.

Signature (Patient or Parent/Legal Guardian): _____Date:_____

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

Healthcare Provider Only: 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:_____

☑	Age (yrs)	Pneumococcal Vaccine (Mfgr)	Dose	NDC
	3+	**Prevnar 20** (Pfizer)	0.5 mL	00005-**2000**-10
	19+	**Capvaxive** (Merck)	0.5 mL	00006-**4347**-02
Sig: Administer 1 shot intramuscularly into the: □ Left Deltoid □ Right Deltoid				

Additional
VIS Date: 5/29/25
Lot Number:
Expiration Date:
Clinic:
No Refills

Revised 7.17.25 CG