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

Pneumococcal Conjugate Vaccine: *What You Need to Know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Pneumococcal conjugate vaccine can prevent **pneumococcal disease**.

Pneumococcal disease refers to any illness caused by pneumococcal bacteria. These bacteria can cause many types of illnesses, including:

- Pneumonia (infection of the lungs)
- Ear infections
- Sinus infections
- Meningitis (infection of the tissue covering the brain and spinal cord)
- Bacteremia (bloodstream infection)

Anyone can get pneumococcal disease, but young children, older adults, and people with certain risk factors are at the highest risk.

Most pneumococcal infections are mild. However, some can result in long-term problems, such as brain damage or hearing loss. Meningitis, bacteremia, and pneumonia caused by pneumococcal disease can lead to death.

2. Pneumococcal conjugate vaccine

Pneumococcal conjugate vaccine helps protect against bacteria that cause pneumococcal disease. There are several pneumococcal conjugate vaccines (PCVs). The specific PCV and number of doses recommended are based on a person's age, vaccination history, and medical status. Your health care provider can help you determine which type of PCV, and how many doses, should be received.

- **Infants and young children** usually need 4 doses of PCV. These doses are recommended at 2, 4, 6, and 12–15 months of age.
- Certain **older children and adolescents** who did not receive the recommended doses as infants or young children need PCV. This depends on age and medical conditions, or other risk factors.
- **Adults 19 through 49 years old** who have not received PCV and have certain medical conditions or other risk factors should receive PCV. Some adults in this group who have already received PCV might be recommended to receive another dose.
- **Adults 50 years or older** who have not previously received PCV should receive a PCV vaccine. Some adults in this group who have already received PCV might be recommended to receive another dose.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of any type of PCV, or to any vaccine containing diphtheria toxoid** (for example, DTaP), or has any **severe, life-threatening allergies**

In some cases, your health care provider may decide to postpone PCV until a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover.

Your health care provider can give you more information.

CDC U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

4. Risks of a vaccine reaction

- Redness, swelling, pain, or tenderness where the shot is given; fever; loss of appetite; fussiness (irritability); tiredness; headache; muscle aches; joint pain; or chills can happen after pneumococcal conjugate vaccination.

Young children may be at increased risk for seizures caused by fever after a PCV if it is administered at the same time as inactivated influenza vaccine. Ask your health care provider for more information.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**.