Prescriber:

Patient Name: **Date of Birth:**

Vaccine:

- ☐ **Comirnaty** (mRNA Pfizer)
- ☐ **mNexspike** (mRNA Moderna)
- ☐ **Spikevax** (mRNA Moderna)
- ☐ **Nuvaxovid** (adjuvanted spike protein, Novavax)
- ☐ **2025-2026 COVID-19 Vaccine** Pharmacist may select formulation

Dosage: Inject a single dose based on age and FDA-approved labeling.

Sig: Pharmacy to administer.

Quantity: 1 dose

Refills: Zero

Prescriber Signature: _____ **Date:** _____