Vaccine Administration Record, Screening, and Patient Consent

Name:____ DOB: _____________ Age: _____ Gender *(circle one)*: M F

Address:_______________________________________City:____________________State:__________Zip: __________

Phone:_______________________ Email:____

Insurance *(mark one)*: ☐ Commercially Insured ☐ Medicare (Medicare ID: ______________) ☐ Uninsured (SSN: ______________)

Primary Care Physician (PCP):____PCP Phone: ___________________________

List Health Conditions:____ Job Title: ______________________

Race *(circle one)*: American Indian/Alaskan Native Asian Black/African American Native Hawaiian/Pacific Islander White Other Unknown

Ethnicity *(circle one)*: Not Hispanic Hispanic Unknown

Question		
1) Have you ever had a severe reaction to any vaccine requiring medical attention? If yes, please describe:	**YES**	**NO**
2) Are you allergic to eggs, thimerosal mercury, neomycin, PEG, polysorbate, or gelatin?	**YES**	**NO**
3) Have you received monoclonal antibody treatment for COVID-19 in the last 90 days?	**YES**	**NO**
4) Have you had Guillian-Barre syndrome, seizures, brain or nerve problems?	**YES**	**NO**
5) Are you pregnant or planning to become pregnant in the next 3 months?	**YES**	**NO**
6) Are you, or anyone in your household, being treated with chemotherapy or radiation for cancer, have HIV/AIDS, any other immune deficiency disorders, or taking oral prednisone or other steroids?	**YES**	**NO**
7) Do you have a bleeding disorder or take "blood thinners" like Coumadin or heparin?	**YES**	**NO**
8) Have you received any vaccine within the last 2 weeks?	**YES**	**NO**
9) Do you smoke, have lung conditions such as COPD or asthma, diabetes, kidney or liver disorders, or sickle cell disease? If yes, have you ever received a pneumonia vaccine?	**YES** **YES**	**NO** **NO**
10) Was your last tetanus booster within the last 10 years?	**YES**	**NO**
11) Are you over the age of 50? If yes, have you received a shingles vaccine?	**YES** **YES**	**NO** **NO**
12) Have you been exposed to anyone diagnosed with COVID-19 in the past 14 days?	**YES**	**NO**
13) Are you experiencing any symptoms of COVID-19 including fever, cough, shortness of breath or loss of taste or smell?	**YES**	**NO**
14) Have you previously been vaccinated with any COVID-19 vaccine? If yes, please complete section below: Vaccine Brand *(Pfizer, Moderna, Astra Zeneca, Johnson & Johnson)*: ______________________________ Date of dose #1: ____________ Date of dose #2 *(if necc)*: _____________ Date of dose #3 *(if necc)*: _____________	**YES**	**NO**

Please read the following statements and sign below on the signature line:

I consent to AuBurn Pharmacy and its staff for my person named at the top of this form to be vaccinated with this vaccine for both the initial and second dose in the series, if applicable. I have been provided the Emergency Use Authorization Fact Sheet or a Vaccine Information Statement prior to vaccination and have the ability to revoke consent at any time. I have had an opportunity to ask questions that were answered to my satisfaction. I believe I understand the benefits and risk of vaccination and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I do hereby authorize AuBurn Pharmacy to release information and request payment from Medicare or commercial insurance. I certify that the information given by me in applying for payment is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf. I consent to inclusion of this immunization data in any state immunization registry for myself or on behalf of the person named below.

____ ___________________________

Signature of person receiving vaccine or authorized representative *Date*

Internal Use Only

Admin Date		**Administrator**		**Admin Signature**	
Vaccine		Notes/Product Sticker	Vaccine		Notes/Product Sticker
LOT/EXP			LOT/EXP		
Manufacturer			Manufacturer		
Dose			Dose		
Location/Route			Location/Route		

___ Scanned as Rx

___ Faxed PCP

___ WebIZ/SMV