Wellness Pharmacy Services

CLIA#: 39D2190211
NPI#: 1811359136

# COVID-19 Vaccination Form

## ❶ PATIENT IDENTIFICATION

| | |
|---|---|
| Patient Name: | Date of Birth: |
| Address: | Gender: |
| City, State, Zip: | Phone #: |
| Race: □ White □ Black of African American □ Asian □ American Indian □ Prefer not to say □ Other: | Ethnicity: □ Not Hispanic or Latino □ Hispanic or Latino □ Other: |

## ❷ SCREENING QUESTIONS

Have you tested positive for Covid-19 in the last 10 days?

Have you had a past severe allergic reaction to a medication, injectable medication or any other vaccine? If yes, please list your allergies.

## ❸ INSURANCE INFORMATION – PROVIDE COPY TO PHARMACY IF INSURED

□ I receive health insurance from this facility

Social Security # (for those 65+):

## ❹ CONSENT & RELEASE

By completing and signing this form you acknowledge the information is true and correct and you consent to receiving the Covid-19 vaccine. Your signature also authorizes entry of the vaccination(s) into the State Immunization Registraty if required.

| | |
|---|---|
| Signature: | Today's Date: |

## VACCINE ADMINISTRATION INFORMATION FOR IMMUNIZER/PHARMACIST ONLY

| | | |
|---|---|---|
| Administation Date: | Vaccine Manufacturer: Pfizer (Comirnaty) | Lot#: |
| Route: Site: □ Left □ Right | Date of Last Vaccination: | Patient Temperature: |
| Immunizer Name & Title: | | Immunizer Signature: |