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 or 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

Medicare ID (if eligible) or Social Security # (for those 65+):

Prescription Card Member ID:	RxGroup:
Prescription Card RxBIN:	Prescription Card RxPCN:

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.

Signature: ______________________________ Today's Date: ____________

Parent/Guardian Signature (if under 18): ______________________ Today's Date: ____________

VACCINE ADMINISTRATION INFORMATION FOR IMMUNIZER/PHARMACIST ONLY

Administation Date:	Vaccine Manufacturer:	Lot#:
Route: Site: ☐ Left ☐ Right	Date of Last Vaccination:	Patient Temperature:
Immunizer Name & Title:		Immunizer Signature: