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 □ American Indian □ Black of African American □ Prefer not to say □ Asian □ 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 do not have health insurance

Medicare ID (if eligible) or Social Security #:	
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:

VACCINE ADMINISTRATION INFORMATION FOR IMMUNIZER/PHARMACIST ONLY

Administation Date:	Vaccine Manufacturer:	Lot#:
Route: Site: □ Left □ Right	Dose#: □ First □ Second □ Third □ Fourth	Patient Temperature:
Immunizer Name & Title:		Immunizer Signature: