

Vaccine(s) Requested: _____

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

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Insurance (mark one): Commercially Insured Medicare (Medicare ID: _____) Uninsured Medicaid

Primary Care Physician: _____ Address: _____ Phone: _____

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

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, gelatin, or any other vaccine component?	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? If yes, provide formulation and date of vaccine (only if seeking 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 since March 2018?	YES YES	NO NO
12) Are you over the age of 60? If yes, have you received an RSV (Respiratory Syncytial Virus) Vaccine?	YES YES	NO NO
13) Have you been exposed to anyone diagnosed with COVID-19 in the past 14 days?	YES	NO
14) Are you experiencing any symptoms of COVID-19 including fever, cough, shortness of breath or loss of taste or smell?	YES	NO
15) Have you previously received a COVID vaccine? If yes, what is the date of most recent vaccine? _____	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
LOT/EXP		LOT/EXP
Manufacturer		Manufacturer
Dose		Dose
Location/Route		Location/Route

___ Scanned as Rx
___ Faxed PCP
___ WebIZ/SMV