Name:	DOB:	Phone:
Address: Zip:	City:	State:
SSN#	Gender:	Primary Care Doctor:
Medicare ID (your red/white/blue card if available)	Ethnicity	

DEEFLAT FAMILY PHARMACY -JOHNSON JOHNSON VACCINE DOCUMENTATION/ CONSENT FORM

Do you have insurance? Yes No (Skip if you have Medicare ID)

RxBin: ID #

RxGroup: RxPCN: Card Holder/ Spouse/Child (please circle)

I have been offered access to the Vaccine Information Statement(s) checked below. I have read and understand the information. I ask that the vaccine(s) be given to me or to the person named below for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Arizona Immunization Registry. I have had a chance to ask questions and I believe I understand the benefits and risks of the COVID-19 vaccine requested. I ask that the vaccine be administered to me or the person for whom I am authorized to make this request:

_____

_____

Signature of Patient or Parent/Guardian Date Adminstrator Date

Johnson Johnson Covid Shot Lot#_____ Exp: _____ IM/ SQ Right/ Left

IMMUNIZATION SCREENING QUESTIONAIR	
1.Are you feeling sick today?	Yes No
2. Do you have allergies to medication, food, vaccine component, or latex?	Yes No
3. Have you had a serious reaction to a vaccine in the past?	Yes No
4. Are you currently taking blood thinner or have a bleeding disorder?	Yes No
5. Have you had seizure, brain or other nervous system problems?	Yes No
6. For women: Are you pregnant or is there a chance you could become pregnant during the next month? STOP- do not receive COVID vaccine if answer yes.	Yes No

7. Have you received any vaccination in the past 4 weeks?	Yes No
8. In the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes No