DEEFLAT FAMILY PHARMACY - VACCINE DOCUMENTATION/ CONSENT FORM

Name:	DOB	Phone
Address: Apartment #: City: State: Zip:		
SSN# Gender:	Medicare ID	Primary Care Doctor:
Profession/Employer (ID Badge required)	Race/Ethnicity	Profession/ Employer

Do you have insurance? Yes No

Plan Name Plan Group ID # Plan Individual ID #

BIN# PCN# Card Holder/ Spouse (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

Moderna Covid19- 1st shot Moderna Covid19- 2st shot Influenza Prevnar 13 Pneumovax 23

Shingrix Tdap Hep A Hep B Other: 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