Paul's Pharmacy
SERVICE YOU DESERVE

Health Mart PHARMACY

COVID-19 Vaccination Voucher

Bring this voucher and a government-issued photo ID to the vaccine location.

Patient Information

Name:	**Gender:**	**DOB:**	**Initials:**
Address:		**City:**	**Phone:**
Insurance Company Name:		**Member ID/Policy #:**	**Group #:**
Primary Care Physician Name:		**Primary Care Physician Phone #:**	
Race:	**Ethnicity:**	**Eligibility:**	
Vaccine requested:		**Dose type:**	
First dose:		**Second dose:**	

Questions below will help us determine your eligibility to be vaccinated today. DK = Don't Know

1. Are you sick or do you have a fever?	YES NO
2. Have you had a severe allergic reaction to food, pet, venom, environmental or oral medication?	YES NO
3. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	YES NO DK
4. Have you had an allergic reaction to polyethylene glycol (PEG), polysorbate or a previous dose of COVID-19 vaccine?	YES NO DK
5. Are you a male between ages 12 and 29 years old?	YES NO
6. Do you have a history of myocarditis or pericarditis?	YES NO
7. Do you have a history of Guillain-Barré syndrome (GBS)?	YES NO
8. Are you a female between ages 18 and 49 years old?	YES NO
9. Do you have a history of heparin-induced thrombocytopenia (HIT)?	YES NO
10. Do you have a bleeding disorder or are you on a blood thinner?	YES NO
11. Are you currently pregnant or breastfeeding?	YES NO
12. Do you have a history of using a dermal filler?	YES NO
13. Do you have a weakened immune system (ie. HIV infection, cancer) or take immunosuppressive drugs/therapies?	YES NO
14. Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?	YES NO
15. Have you had COVID-19 and were treated with monoclonal antibodies or convalescent serum?	YES NO

Appointment Information

Appointment Date: CALL FOR APPT	**Appointment Time:**	**Location:** Pauls Pharmacy 222 OAKRIDGE COMMONS, SOUTH SALEM NY 10590	**Voucher #:**

Please bring an identification card to your appointment, if you have one.

I hereby certify that the above information I provided is true and correct to the best of my knowledge.

Patient/Legal Guardian Name:_____ Signature:_____ Date:_____

The following is to be completed by the health care provider ONLY.

Vaccine Administrator Name (Print):	Professional Designation:	Signature:
Intern Name (Print):	Administration Date/Date Fact Sheet/Immunization Card Given:	

Vaccine	Lot #	Exp. Date	Manufacturer	NDC	Dose #	Dosage mL	Site	Route	RPh Init.
			Pfizer-BioNTech				LA RA	IM	
			Moderna				LA RA	IM	
			Janssen				LA RA	IM	