

## COVID-19 Vaccine Patient Screening/Vaccine Administration Record

### Patient Information

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Last Name	First Name	Date of Birth	Gender	Race/Ethnicity
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Address	City	State	Zip
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### Insurance Information

*Please ensure to record both pharmacy and medical insurance information since there are multiple ways that the vaccine administration can be billed at the pharmacy.*

Non-Medicare	Pharmacy	Medical	Medicare (Red, White & Blue Card) #
Insurance Plan Name			
Member/Recipient ID			
RX Bin		N/A	
RX PCN		N/A	
Group Number			

Are you the cardholder? (please circle one):          YES          NO

If no, please provide cardholder's name, date of birth, and relationship:

Cardholder Name	Date of Birth	Relationship to Patient

### Patient Consent

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I understand the benefits and risks of the vaccination as described in the Emergency Use Authorization (EUA) and/or CDC Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I request the vaccine be given to me or the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release.

Signature of Person to Receive Vaccine (or Parent/Guardian, if a minor):

\_\_\_\_\_ Date: \_\_\_\_\_

*Print Parent/Guardian name if recipient is a minor:* \_\_\_\_\_ Date: \_\_\_\_\_

I have received a copy of the notice of Privacy Practices. I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the Pharmacy and my rights with respect to my health information, including reporting to the State Vaccination Registry and/or local or state Departments of Health, federal Department of Health and Human Services, and the Center for Disease Control and Prevention.

Signature of Person to Receive Vaccine (or Parent/Guardian, if a minor):

\_\_\_\_\_ Date: \_\_\_\_\_

*(Print Parent/Guardian name if recipient is a minor):* \_\_\_\_\_ Date: \_\_\_\_\_

**To be completed by Vaccine Administrator**

Vaccine	Date Administered	Vaccine Lot#	Expiration Date	MFR	Dosage	Injection Site	VIS/EUA Date	Dose #1 or #2

Administering Immunizer Signature: \_\_\_\_\_ Date: \_\_\_\_\_