COVID - 19 VACCINE REQUEST

PATIENT INFORMATION:

Patient Name:_____ **Phone:** _____

Birthday:_____ Gender: M or F **Last 4 of SS#** _____

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

Ethnicity: **Race:** ☐ American Indian/Native American/Alaskan Native ☐ Asian ☐ Other

☐ Hispanic ☐ Black/African American ☐ Native Hawaiian ☐ White

☐ Non-Hispani **Please list Medical Conditions / Employer:**

BILLING INFORMATION PLEASE CHECK HERE ☐ IF No Insurance AND provide full SS# above.

MEDICARE (RED, WHITE, & BLUE) if you have PART B #_____

Using a PRESCRIPTION Card: **ID#**_____ **Rx PCN#**_____ **Rx BIN** _____ **Rx Grp** _____

VA Benefits, Please provide VA Member ID#

MEDICAL SCREENING QUESTION - REQUIRED

1. Are you sick today?	Y	N
2. Do you have allergies to medications, food, vaccine component, or latex? Please list:_____ ***If vaccine allergy, do not vaccinate; if other allergy, monitor 30mins.***	Y	N
3. Ever had a serious reaction after receiving a vaccination (prior dose of COVID-19 vaccine)?	Y	N
4. Do you have an immune-suppressing condition or medicine? *If yes, be aware that vaccine effectiveness may be limited.*	Y	N
5. Do you have a bleeding disorder or are you taking a blood thinner? *If yes, be aware of possible bleeding/bruising.*	Y	N
8. Have you received any vaccinations in the past 14 days?	Y	N
4. Have you tested positive for COVID-19 in the last 10 days? *If yes, reschedule.*	Y	N
5. Have you received a COVID-19 vaccine in the past? ***If yes, complete information below***	**Y**	**N**
Please provide vaccine card. *Date of Vaccine:* *Manufacturer:*		

CONSENT FOR VACCINATION

I have been given and have read or have had explained to me, the information in the "FACT SHEET FOR RECIPIENTS AND CAREGIVERS." I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine requested and ask that the vaccine checked below be given to me or the person named for whom I am authorized to make this request. I authorize Kare Drug to prescribe, administer, and bill for the requested vaccine to seek reimbursement for the vaccine and administrative costs. I have provided accurate and current insurance information. I acknowledge that the pre-vaccination questionnaire has been answered truthfully and honestly to the best of my ability. I allow immunization information to be entered into the New Mexico Statewide Immunization Information System (NMSIIS) and be released to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status.

Patient Signature: _____ **Date:** _____

IMMUNIZATION(S) PROVIDED:

	Vaccine	Date	NDC	Site	Lot #	Exp. Dt.	EUA date
☐	Moderna COVID-19		80777-0273-99				Dec-20
☐	Johnson & Johnson COVID-19		59676-0585-05				Feb-21
☐		**Vaccinator Name and Title:**					

Prescribed By: _____