

# IMMUNIZATION DOCUMENTATION AND CONSENT FORM

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ PCP's Phone Number: \_\_\_\_\_

Please select the vaccine you would like to receive:

☐ Influenza (FLU) ☐ COVID-19 (MODERNA) ☐ Other:

Eligibility Attestation for COVID-19 vaccine (SELECT ONE OPTION ONLY):

☐ I am 65 years or older (WRITE AGE CLEARLY): \_\_\_\_\_ ☐ I am 12-64 years old and have at least one medical condition

☐ I am under 65 with no underlying conditions

## IMMUNIZATION SCREENING QUESTIONNAIRE

Do you feel sick or unwell today?	Y	N	Do you have a weakened immune? Active cancer, HIV/AIDS, transplant, or other condition?	Y	N
Do you have any allergy to latex or vaccine components?	Y	N	Do you have history of myocarditis or pericarditis?	Y	N
Do you have a lung, heart, kidney, or metabolic disease? If yes, please list:	Y	N	It has been > 3 months since my last COVID vaccine or having COVID	Y	N
Do you have a seizure or brain disorder, Guillain-Barre Syndrome, nervous system disorder, or Multisystem Inflammatory Syndrome (MIS-A or MIS-C)?				Y	N

I consent to allow the provider to administer the above-listed immunization(s). I understand that the provider will upload this information to the New York State Immunization Information System (NYSIIS) and that it may be accessible to other healthcare providers. I agree to pay for any financial responsibility associated with the above-listed immunization at the time of receiving the service. I acknowledge that insurance coverage is not guaranteed, and if my insurance plan denies or later reverses payment for this immunization, I am responsible for the full cost. I also understand that this provider is not responsible for any side effects or harm caused by my receiving this immunization.

\*I am aware mNEXSPIKE will be administered for individuals over 65 when available, and all other eligible individuals will receive SPIKEVAX

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

## \*\*BELOW IS FOR IMMUNIZER USE ONLY\*\*

VACCINE ADMIN	SITE	LOT / STICKER	VIS DATE
Influenza (FLU)	<input type="checkbox"/> LD <input type="checkbox"/> RD		
COVID 19 (SPIKEVAX / mNEXSPIKE)	<input type="checkbox"/> LD <input type="checkbox"/> RD		
OTHER	<input type="checkbox"/> LD <input type="checkbox"/> RD		

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

RX LABEL

(place additional labels on back)

IMMUNIZER STAMP