Wellness Pharmacy Services

CLIA#: 39D2190211
NPI#: 1811359136

COVID-19 Vaccination Form

1 PATIENT IDENTIFICATION

Patient Name:	Date of Birth:
Address:	
City, State, Zip:	Gender:
Email:	Phone#:
Race: □ White □ Black of African American □ Asian □ American Indian □ Prefer not to say □ Other:	Ethnicity: □ Not Hispanic or Latino □ Hispanic or Latino □ Other:

2 SCREENING QUESTIONS

What is your occupation or job title?
If under 65, do you have any pre-existing conditions? If so, please list.
Have you tested positive for Covid-19 in the last 90 days?
Have you had a past severe allergic reaction to a medication, injectable medication or any other vaccine? If yes, please list your allergies.
Have you had any other vaccinations in the last 14 days? (ie: Flu, Tdap, Td, Shingles, Pneumococcal, etc)

3 INSURANCE INFORMATION

□ I do not have health insurance

Medicare ID (if eligible) or Social Security #:	
Prescription Card Member ID:	RxGroup:
Prescription Card RxBIN:	Prescription Card RxPCN:

4 CONSENT & RELEASE

By completing and signing this form you acknowledge the information is true and correct and you consent to receiving the Covid-19 vaccine.

Signature:	Today's Date: