INFLUENZA & COVID-19 VACCINATION ADMINISTRATION RECORD

Hudson Drug and Hallmark Shop
108 N. Market St., Paxton, IL
(217) 379-4858

Last Name (Please Print Clearly) | First Name | Middle Name

Mailing Address | City, State, & ZIP

Phone Number | Date of Birth (MM/DD/YY) | Gender

Insurance ID # | BIN # | PCN # | RX Group

Medicare # (only if 65 years or older) | If no insurance, provide state ID or Driver's License #

Read the Questions Below and Check the Appropriate Box	**YES**	**NO**
1) Are you sick with a fever or feeling ill today? Displaying any COVID-19 symptoms	☐	☐
2) Have you had an adverse reaction (allergic reaction/requiring medical attention) to any vaccine in the past?	☐	☐
3) Do you have a history of developing Guillain-Barre Syndrome?	☐	☐
4) Are you taking any medication that may cause you to bleed, such as aspirin or Coumadin?	☐	☐
5) Do you have a weakened immune system caused by something such as HIV or cancer, or do you take immune suppressing drugs or therapies?	☐	☐
6) For women: Are you pregnant or breastfeeding?	☐	☐
COVID Vaccine Only		
7) Have you received a COVID-19 vaccine? Manufacturer: _____	☐	☐
8) Have you received passive antibody therapy as treatment for COVID 19?	☐	☐

I request the vaccine to be given to me or to the person named above, a minor for whom I represent and I am authorized to sign this consent form. I understand the benefits and risks of the influenza and/or COVID-19 vaccine as described in the influenza VIS and/or the Emergency Use Authorization (EUA) Fact Sheet of which I was provided with this consent form (online or in print). I have had a chance to ask questions that were answered to my satisfaction. If insured, I authorize the pharmacy to bill my insurance on my behalf for the immunization. If uninsured, I attest that I do not have any insurance, including, but not limited to Medicare, Medicaid, or any other private or government-funded benefit plan. If uninsured, I authorize the pharmacy to use my social security number, state identification number, or driver's license number to bill the U.S. Health Resources & Services Administration's COVID-19 Program on my behalf for the immunization. If uninsured, I agree to cover all costs related to my influenza vaccine.

Signature | Date

Administrative Use Only

Influenza Vaccine

Vaccine type & Lot #

Injection Site: ☐ Left Arm ☐ Right Arm

COVID Vaccine

Vaccine type & Lot #

Injection Site: ☐ Left Arm ☐ Right Arm

☐ Primary dose ☐ Booster dose

Administrator Signature | Date