

PATIENT INFORMATION (VACCINE RECIPIENT) * REQUIRED			
Last Name*		First Name*	
Date of Birth* MM / DD / YY	Age*	Gender* ☐ M ☐ F	Phone*
☐ I want to receive text message alerts regarding my prescriptions.			Email
Address*		City*	State* Zip*
Race*: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Unknown		Ethnicity*: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown	
Describe or list any existing medical conditions:			
I want to receive the following vaccination(s)*: ☐ Flu ☐ COVID-19 ☐ Other:			
Parent/Guardian Name (if patient is minor):		Relationship:	
We will send vaccination information from this visit to your doctor/primary care provider using the contact information provided			
Doctor/Primary Care Provider Name		Provider Phone Number	
Address		City	State Zip

SCREENING QUESTIONS (REQUIRED)		YES	NO	Don't Know
1	Are you feeling sick today? (For example: a cold, fever, acute illness) Today's date: _____	☐	☐	☐
2	Do you have allergies to latex, medications, food, or any vaccine? (examples: polyethylene glycol, polysorbate, eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal) Please list _____	☐	☐	☐
3	Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	☐	☐	☐
4	Do you take anticoagulation medication? (For example: Warfarin, Coumadin or other blood thinners)	☐	☐	☐
5	Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐	☐
6	Have you had a seizure, brain, or other nervous system problem?	☐	☐	☐
7	Do you have any chronic health condition such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, obesity, sickle cell disease, diabetes, heart disease? Please list _____	☐	☐	☐
8	Have you received any vaccinations in the last 14 days? Please list _____	☐	☐	☐
9	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐

PRESCRIPTION INSURANCE INFORMATION			
ID	BIN	PCN	Group
Are you the cardholder? ☐ YES ☐ NO			
If no, please provide cardholder's name, date of birth (MM/DD/YYYY) & relationship: _____			

MEDICARE INFORMATION (RED, WHITE, AND BLUE CARD)	
MEDICARE No.	SSN

PATIENT CAPACITY & CONSENT FOR SERVICES: I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient; or (c) legally authorized to consent on behalf of the patient. I hereby give my consent to **VN Pharmacy** and its licensed healthcare staff ("Provider") to administer the requested vaccine(s) or medical treatment(s).

INFORMED CONSENT & RISK ACKNOWLEDGMENT: I acknowledge receiving, reading, or having explained to me the applicable Vaccine Information Statement (VIS), Texas DSHS information sheet, or FDA Emergency Use Authorization (EUA) Fact Sheet. I understand the risks and benefits associated with the requested vaccine(s), have had the opportunity to ask questions, and understand there is no guarantee against adverse reactions. I agree to remain near the administration area for 15–30 minutes post-vaccination for observation.

FINANCIAL RESPONSIBILITY & INSURANCE AUTHORIZATION: I authorize Provider to release necessary medical information to Medicare, Medicaid, or my private insurance carrier to bill for services rendered. I agree that I am fully financially responsible for any co-pays, deductibles, coinsurance, or services not covered by my insurance.

Signature of patient or guardian: _____ Date: _____

----- FOR PHARMACY USE ONLY -----

PRODUCT	MANUFACTURER	VOL (ML)	DOSE #	SITE	ROUTE	LOT #	EXP DATE	VIS VER. DATE
☐ COVID SPIKEVAX	☐ Moderna	0.5		L / R	IM		/ /	1/31/25
☐ FLUCELVAX	Sequirus	0.5	1	L / R	IM		/ /	1/31/25
☐ FLUAD	Sequirus	0.5	1	L / R	IM		/ /	1/31/25
☐ AFLURIA	Sequirus	0.5	1	L / R	IM		/ /	1/31/25
☐ FLUZONE		0.5	1	L / R	IM		/ /	1/31/25
							/ /	/ /
							/ /	/ /
							/ /	/ /
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Administering Immunizer:	Administration Date:
Signature: _____	

NOTES

Affix Rx Label