COVID-19 VACCINATION ADMINISTRATION RECORD

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

Note: You must wear a mask covering both your nose and mouth

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 Following Questions And Check The Box That Applies

	YES	NO
1. Are you sick with a fever? Or feeling severely ill today? Displaying any COVID-19 symptoms?	☐	☐
2. Have you received a COVID-19 vaccine? __ yes __no Manufacturer_____		
3. Have you ever had a positive COVID-19 test?	☐	☐
4. Have you received any vaccine in the past 14 days?	☐	☐
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐
6. Have you had an adverse reaction (i.e., requiring medical attention) to any vaccine in the past?	☐	☐
7. Do you have a weakened immune system caused by something such as HIV or cancer, or do you take immuno-suppressant drugs or therapies?	☐	☐
8. For women: Are you pregnant or breastfeeding?	☐	☐
9. For people receiving the booster vaccine: I am 18 to 64 years old and...		
• I have an underlying medical condition that puts me at high risk for severe COVID-19 illness	☐	☐
• I live in an institutional setting	☐	☐
• I am a front line worker in a high-risk occupation	☐	☐

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 COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet, a copy 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. I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur. I understand that I will be receiving the vaccination at no cost to me. 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. I understand that at this time, some COVID-19 vaccines require 2 doses given 21-28 days apart dependent on the manufacturer. If this is my first dose of the COVID-19 vaccine and a second dose is required (Pfizer & Moderna only), I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the series.

Signature _____ Date _____

Injection Site: ☐ Right Arm ☐ Left Arm

Administrative Use Only

Type of Vaccine _____

☐ Dose 1 ☐ Dose 2

☐ Booster Dose

Manufacturer & Lot # _____

Administrator Signature _____ Date _____

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