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 Attestment 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)	☐ LD ☐ RD		
COVID 19 (SPIKEVAX / mNEXSPIKE	☐ LD ☐ RD		
OTHER	☐ LD ☐ RD		

Immunizer Signature:_____ Date:_____

RX LABEL

(place additional labels on back)

IMMUNIZER STAMP