Office Use Only	Date:
Injection Site:	
Vaccine Lot EXP	
Vaccinator	

Patient Registration/Consent Form

Place label here

Vaccine being requested Flu___ Senior Flu___ Shingrix___ TDAP___ Other_____
Covid Pfizer____ Covid Moderna____ ** Flip page over for booster info**

Person receiving vaccine

First Name	MI	Last Name		
Address	City		State	Zip
Phone	Physician			
Date of Birth (MM/DD/YYYY)	Age	Gender		

Parent or Legal Guardian (if applicable)

First Name	Last Name
Relationship to Client	Phone

Screening Questions for person receiving vaccine (Please Circle)

1.	Are you feeling sick today? If yes, please do not attend the clinic.	YES	NO
2.	Have you ever had a flu vaccine?	YES	NO
3.	Have you ever had a serious reaction to any vaccine in the past? *	YES	NO
4.	Do you have an allergy to a component of the vaccine? (MSG, gentamicin, gelatin)	YES	NO
5.	Have you ever been diagnosed with Guillain-Barre Syndrome?	YES	NO
6.	Are you pregnant or possibly pregnant?	YES	NO

If you answered YES to any of questions 3-6, please contact your medical provider to receive your vaccination.

Consent to Administer Vaccination & Enter Information Into Immunization Registry

To the best of my knowledge, I understand the benefits and/or risks of the vaccine I am receiving today. I hereby give consent to Meadowmont Pharmacy (MMRX) staff for the administration of the vaccine to myself or for the individual for whom I am authorized to make said request. I have received a copy of the most up-to-date Vaccine Information Statement (VIS). I understand that I will have the chance to ask questions and have them answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. I fully release and hold harmless Meadowmont Pharmacy, its officers, directors, and employees from all liabilities or claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. MMRX is authorized to enter my vaccination information into the statewide immunization database. This information could be shared with my healthcare provider as part of my medical record.

I FULLY UNDERSTAND THAT I WILL BE ULTIMATELY RESPONSIBLE FOR ANY CHARGES if I am not a covered person under the insurance plan (program listed above), the services are not covered services, or any co-pays, deductibles or coinsurance obligations apply. Furthermore, I agree to remain near the vaccination location for approximately15-20 minutes after administration for observation by the administering healthcare provider.

Signature:	**Date:**
Relationship to Client:	

A booster dose of the COVID-19 Moderna or Pfizer vaccine is recommended if you:

- Received your second vaccine dose at least 6 months ago, AND
- Are age 65 or older, or
- Are age 18 or older who live in long-term care settings, or
- Are age 18 or older who have underlying medical conditions, or
- Are age 18 or older who are at increased risk due to social inequity, or
- Are age 18 or older who work or live in high-risk settings

A booster dose of the COVID-19 Janssen (Johnson and Johnson) vaccine is recommended if you:

- Received your first dose of the Janssen vaccine at least 2 months ago, and
- Are age 18 or older

Individuals eligible for a booster may receive either the same or a different COVID-19 vaccine as a booster dose, depending on advice from a health care provider, individual preference, availability, or convenience.

**Examples of underlying medical conditions may include, but are not limited to the following:

Cancer, Cerebrovascular disease or Stroke, Chronic Kidney Disease, Chronic Lung Diseases (including COPD), Asthma, Interstitial Lung Disease, Cystic Fibrosis, or Pulmonary Hypertension), Dementia or other Neurological Conditions, Diabetes, Down Syndrome, Heart Conditions (such as Heart Failure, Coronary Artery Disease, or Cardiomyopathies), HIV/AIDS, Immunocompromised State (weakened immune system), Liver Disease, Overweight or Obesity (BMI >30), Pregnancy and Recent Pregnancy, Sickle Cell Disease or Thalassemia, Smoking (current or former), Solid Organ or Blood Stem Cell Transplant, Substance Use Disorder

**Example of occupations at increased risk for Covid-19 exposure and transmission may include, but are not limited to the following:

First responders (healthcare workers, firefighters, police, congregate care staff), Education staff (teachers, support staff, daycare workers), Food and agriculture workers, Corrections workers, USPS workers, Public transit workers, Grocery store workers

By signing below, I confirm that I meet the requirements above and am eligible for a COVID-19 booster dose.

Print Name_____

Signature _____