Sunshine Pharmacy - COVID-19 Vaccine Administration Record

SECTION 1	CLIENT INFORMATION (Please PRINT clearly)

Today's Date: ____________________

Legal Name: ____
Last Name First Name Middle Name

______________________ Other names used since Birth______________________
Birthdate MM/DD/YYYY (Maiden Name, etc.):

Gender: ☐ Male ☐ Female

Address: ____
Street Address

____
City State Zip Code

Phone Number: ______________________ Email: ______________________

(Area Code) Phone Number

Race: ☐ White ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ Native Alaskan/American Indian
☐ Asian ☐ Multi-Racial (Select all that apply)

Ethnicity: ☐ Non-Hispanic/Latino
☐ Hispanic/Latino

SECTION 2	CONSENT

CONSENT FOR SERVICES: I have read or have had explained to me, the information contained in the Emergency Use Authorization Fact Sheet regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s). I ask that the vaccine(s) be given to me, or to the person for whom I am authorized to make this request. I also authorize the Sunshine Pharmacy LLC (d/b/a Sunshine Pharmacy) to release my immunization record information, or the immunization record information of the person for whom I am authorized to make this request to other health care provider(s) as needed and to other public health authorities (e.g. for entry into an immunization registry for the Covid-19 Vaccine reporting requirements).

By signing below, I hereby acknowledge that I have read and fully understand the applicable statements on this form.

SIGNATURE of Client/Legal Guardian ______________________ Date ______________

PRINT NAME of Client/Legal Guardian ______________________________________

ENTERED into MICR by:	
Date ENTERED in MICR:	

SECTION 3	Vaccine Documentation (to be filled in by pharmacy)
Dose Number	☐ Covid-19 Vaccine Dose #1 ☐ Covid-19 Vaccine Dose #2 ☐ Pfizer Bivalent Covid-19 Booster ☐ Moderna Bivalent Covid-19 Booster
Vaccination Checklist	☐ Birthdate Confirmed ☐ Screening Questions Reviewed ☐ EUA Fact Sheet Given ☐ Provided COVID-19 Vaccination Record
Staff Administering Vaccine	
Date	

Vaccine	MFR	Lot #	Dose/Vol	Site		Route
Covid-19 mRNA	☐ Pfizer Bivalent Booster		☐ 0.3 mL dose	☐ Right Arm (Deltoid) ☐ Left Arm (Deltoid)	☐ Right Thigh ☐ Left Thigh	IM
Covid-19 mRNA	☐ Moderna Starter Dose		☐ 100 mcg/ 0.5 mL dose	☐ Right Arm (Deltoid) ☐ Left Arm (Deltoid)	☐ Right Thigh ☐ Left Thigh	IM
Covid-19 mRNA	☐ Moderna Bivalent Booster		☐ 0.5 mL dose	☐ Right Arm (Deltoid) ☐ Left Arm (Deltoid)	☐ Right Thigh ☐ Left Thigh	IM

SECTION 4 INSURANCE – PATIENT OR AUTHORIZED PERSON TO COMPLETE

	Pharmacy card	Medical card
Insurance Plan/Plan ID:		
Member/Recipient ID #:		
RX BIN:		N/A
RX PCN:		N/A
Group Number:		

Are you the cardholder? ☐ Yes ☐ No

If no, please provide cardholder's name, date of birth (MM/DD/YYY) and relationship: **Healthcare provider only:** Individual refused to provide insurance information when

I attempted to obtain the insurance information from the individual.

☐ Yes

Medicare	Medicare Part B
Medicare number:*	
Last 4 digits of SSN:†	

Please be sure to record BOTH your Pharmacy & your Medical insurance coverages as it may be required for billing of vaccinations at Sunshine Pharmacy.

COVID-19 VACCINATION ONLY

If uninsured: I attest that I do not have any medical or pharmacy insurance. ☐ Yes

Drivers license/State ID number* (circle one) ______

Issuing state: ______

*For verification and coverage Initial here: