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 _____
MM/DD/YYYY (Maiden Name, etc.):

Gender: ☐ Male ☐ Female

Address: _____
Street Address

_____
City State Zip Code

Phone Number: _____
(Area Code) Phone Number

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

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
Dose Number	☐ Covid-19 Vaccine Dose #1 ☐ Covid-19 Vaccine Dose #2
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		☐ 30 mcg/ 0.3 mL dose	☐ Right Arm (Deltoid) ☐ Left Arm (Deltoid)	☐ Right Thigh ☐ Left Thigh	IM
Covid-19 mRNA	☐ Moderna		☐ 100 mcg/ 0.5 mL dose	☐ Right Arm (Deltoid) ☐ Left Arm (Deltoid)	☐ Right Thigh ☐ Left Thigh	IM
Covid-19 vector-nr	☐ Janssen		☐ 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:		

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

Please ensure to record BOTH pharmacy AND medical insurance information since there are multiple ways vaccinations can be billed at Sunshine Pharmacy

*Number on the red, white and blue Medicare card.
For insurance confirmation purposes only.

COVID-19 VACCINATION ONLY

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

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

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

Issuing state: _____

*For verification and coverage Initial here: