SUWANEE PHARMACY

2027 Lawrenceville-Suwanee Rd Suite 700
Suwanee, GA 30024
678-878-2082

Last Name	First Name	M.I.	Gender

Date of Birth	Phone	Age	Race

Street Address	City, State, Zip

Primary Care Physician	Office Phone Number	State	

VACCINATION REQUEST

Age	MODERNA	PFIZER	J & J	NOVAVAX	OTHER
Pediatric* (6mon-5 year) **&** >33lbs+	☐ 1st ☐ 2nd ☐3rd*	X	X	X	INFLUENZA ☐
Child (5-<12 year)	X	☐ 1st ☐ 2nd ☐3rd*	X	X	PNEUMONIA ☐
Teenage (12 years +)	X	☐ 1st ☐ 2nd ☐3rd ☐ 4th	X	☐ 1st ☐ 2nd	SHINGLES ☐
Adult (18 years)+	☐ 1st ☐ 2nd ☐3rd ☐ 4th*	☐ 1st ☐ 2nd ☐3rd ☐ 4th*	☐ 1st	☐ 1st ☐ 2nd	OTHER ☐

INSURANCE INFORMATION

Insurance Carrier	ID	BIN	PCN

Group	Cardholder Name	Cardholder Date of Birth

Relationship to Patient Self ☐ Parent ☐ Legal Guardian ☐ Spouse☐	MEDICARE #

SCREENING QUESTIONS

Is the patient sick today?	☐ Yes	☐ No
Has the patient had a life threatening reaction to any injectable medication or to a vaccine component (ex. eggs, thimerosal, gelatin, neomycin, phenol, or bovine protein) or latex? Yes, list _____	☐ Yes	☐ No
Does the patient have long-term health problem such as heart disease, lung disease, liver disease, asthma, metabolic disease (ex. diabetes) or blood disorder? Yes, list _____	☐ Yes	☐ No
Has the patient had a seizure or any other brain or other nervous system problem (i.e., Guillain-Barré Syndrome) after receiving a vaccine?	☐ Yes	☐ No
Does the patient have a history of fainting, particularly with vaccines?	☐ Yes	☐ No
For Women: Is the patient pregnant or considering becoming pregnant in the next three months, or currently nursing?	☐ Yes	☐ No

I have read the Emergency Use Authorization (EUA) Fact Sheet or the VIS about the vaccine. I understand the benefits and risks of the vaccine. I give permission for the above-named patient to receive the vaccine indicated. I authorize billing insurance for the vaccine administration fee for the vaccine provided. I have also received notice of my privacy rights, and I have been given or offered a copy of the ***Georgia Department of Public Health Notice of Privacy Practices.***" I understand this information is available upon request, as well as available for review at the time of vaccination.

Signature or Signature of Representative (Power of Attorney)_____Date_____

(To Be Completed by Vaccine Administrator)

Date Vaccine and VIS Given Same as above	VIS or EUA Fact Sheet Date Same as above	Clinical Site Suwanee Pharmacy	County Code Gwinnett	NCES #

Vaccine Given: ☐COVID-19 ☐ Influenza ☐ Pneumococcal ☐Shingles ☐Other

Manufacturer:	Lot Number	NDC #	Expiration Date	Site of Injection: LA RA	Route : IM SQ

Pharmacist Signature	Date