SUWANEE PHARMACY

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

Last Name	First Name	M.I.	Gender

Last 4 Digits of Social Security Number	Date of Birth	Age	Race

Street Address	Phone

City	County	State	Zip

VACCINATION REQUEST

Age	MODERNA	PFIZER	J & J
Pediatric* (6 months - 5 year) **&** >33lbs+	☐ 1st ☐ 2nd ☐3rd*	X	X
Child (5 years - <12 year)	X	☐ 1st ☐ 2nd ☐3rd ☐ 4th*	X
Teenager (12 years +)	X	☐ 1st ☐ 2nd ☐3rd ☐ 4th*	X
Adult (18 years)+	☐ 1st ☐ 2nd ☐3rd ☐ 4th*	☐ 1st ☐ 2nd ☐3rd ☐ 4th*	☐ 1st ☐ 2nd

* Moderately or severely immunocompromised or age based

INSURANCE INFORMATION

Insurance Carrier	ID	BIN	PCN

Group	Cardholder Name	Cardholder Date of Birth

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

VACCINATION & HEALTH-RELATED INFORMATION

Has the patient ever received a COVID-19 vaccination? If yes, date given_____ Manufacturer_____	☐ Yes	☐ No
Does the patient have long-term health problems with: • Immuno-compromised condition or taking a medicine that affects your immune system? (Heart Disease • Lung Disease • Asthma • Kidney or Liver Disease • Metabolic Disease ,such as Diabetes • Bleeding disorder or take a blood thinner)	☐ Yes	☐ No
Has the patient had life threatening reaction to any injectable medication, including a COVID-19 vaccine, or to a vaccine component(examples eggs, thimerosal, gelatin, neomycin, phenol, or bovine protein)?Yes, list_____	☐ Yes	☐ No
For Women: Are you pregnant or considering becoming pregnant in the next three months, or currently nursing?	☐ 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

I have read the Emergency Use Authorization (EUA) Fact Sheet or the VIS about the COVID-19 virus and vaccine. I understand the benefits and risks of the COVID-19 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	VIS or EUA Fact Sheet Date (circle one)	Clinical Site	County Code	NCES #

Vaccine Given: ☐Pfizer ☐ Child Pfizer ☐Moderna ☐Pediatric Moderna ☐Johnson & Johnson

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

Pharmacist Signature	Date