

Name (First, MI, Last): _____ DOB: ____/____/____ Age ____

Full Address: _____ Zip Code _____

Phone#: (____) _____ - _____ I Gender: M / F / Other I Race & Ethnicity: _____

Emergency Contact or Guardian Name: _____

Emergency Contact or Guardian Phone: _____ Relationship to Patient: _____

Primary Care Physician: _____

Allergies (drugs, food, vaccines)/Health Conditions: _____

Rx BIN: _____ Rx PCN: _____

Rx Group: _____ Member ID: _____

SSN# or Medicare #: _____ Medicaid (circle) Y / N

Please answer the questions below to help determine if the vaccine(s) may be given today. If you answer yes, please explain.

- ____ Yes ____ No 1. Are you sick today? (mild illnesses like upper respiratory infections or diarrhea are okay)
 ____ Yes ____ No 2. Have you ever had a severe reaction to a vaccine or are you allergic to eggs, thimerosal, streptomycin, or neomycin?
 ____ Yes ____ No 3. Have you had a seizure or a brain disorder, other nervous system problem, or guillain-barre syndrome (paralysis)?
 ____ Yes ____ No 4. Have you had a pneumococcal vaccine (pneumonia shot)?

5 - 10 for Covid vaccines only

- ____ Yes ____ No 5. When was your last Covid vaccine? _____
 ____ Yes ____ No 6. Have you been diagnosed or tested positive for Covid-19 in the past 90 days?
 ____ Yes ____ No 7. Have you received monoclonal antibodies or convalescent plasma as part of Covid-19 treatment in the past 90 days?
 ____ Yes ____ No 8. Do you have a bleeding disorder, take a blood thinner, breast feed, or are currently pregnant?
 ____ Yes ____ No 9. **If <age 65:** I spoke to a clinician about the risks and benefits in shared clinical decision-making and understand that benefits are greatest for people with the most risk of serious disease and lowest for people without increased risk. I attest that I have any conditions that would put me at high risk of Covid-19 complications.
 ____ Yes ____ No 10. Have you had a fever, chills, cough, shortness of breath, trouble breathing, fatigue, muscle or body aches, headache, loss of taste or smell, sore throat, congestion, runny nose, nausea, vomiting, or diarrhea in the last 90 days?

I have read, or have had explained to me, the information regarding the vaccine(s) I am receiving.. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and authorize the administration of the vaccine to me or the person named below for whom I am authorized to make this decision. I, for myself, my heirs, and executors release Medicine Shoppe Pharmacy, its employees, volunteers, affiliated physicians, any insurance provider, and/or any retail or external site from any and all claims arising out of, or in any way related to my receipt of this or these immunization(s). Medicine Shoppe Pharmacy and the aforementioned related parties shall not at any time or to any extent be liable or responsible for any loss, injury, death, or damage to be suffered or sustained at any time as a result of this vaccination program. **I agree to wait in the vaccination location for approximately 15 minutes for observation after vaccination.** Furthermore, I authorize Winkelmann Drug or Medicine Shoppe Pharmacy release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf to Allwin as my Medicare Part B provider. This notification is being provided pursuant to § 338.010.13, RSMo. I understand and acknowledge the administration of this vaccine will be entered into the ShowMeVax system administered by the Missouri Department of Health and Senior Services unless I indicate otherwise.

By signing this form, I attest to receiving clinical services from the pharmacy.

Signature: _____ Date: _____

Pfizer Covid Vaccine I Moderna Covid Vaccine I Fluzone Tri PF I Fluzone HD I Boostrix I Havrix I Engerix-B I Shingrix I Menactra I Vaxneuvance 15 I Pneumovax 23 I Pevnar 20 # 1 dose Inject into deltoid by qualified vaccinator as directed by standing order. No refills. DUR: PH, MA, 3N, 11; incentive amount (E3): \$60 <u>Dr. Jason Wang, PharmD or Dmitri Postnov, PharmD or Julie Elbl, PharmD or Matthew Marting, PharmD</u> Substitution Permitted Substitution not Permitted	
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For Pharmacy use only. For billing purposes only. Date vaccines & VIS/EUA given are same as date signed unless otherwise noted by Winkelmann Drug.

Vaccine, Qty, and Manufacturer (circle)		Injection Site/Route	Vaccine, Qty, and Manufacturer (circle)		Injection Site/Route	Administered by RPh or:
Pfizer Age 12+ Comirnaty 0.3 ml NDC: 0069-2631-10	Lot #	IM Deltoid Left I Right	Fluzone (2026-2027) 0.5 ml by Sanofi NDC: 49281-0426-50	Lot#	IM Deltoid Left I Right	Tabitha Berry, CPhT Other: _____
Moderna Age 12+ Spikevax 0.5 ml NDC: 80777-0114-96	Exp. Date:		Flucelvax (2026-2027) 0.5 ml by Seqirus NDC: 70461-0656-03	Exp.		Supervising RPh: Dmitri Postnov, PharmD
Moderna Age 65+ mNEXSPIKE 0.2 ml NDC: 80777-0401-60	Lot #		Flublok (2026-2027) 0.5 ml by Sanofi 49281-0725-10	Lot #		Jason Wang, PharmD Julie Elbl, PharmD
			Fluzone HD (2026-2027) 0.5 ml by Sanofi Pasteur NDC: 49281-0126-65			Matthew Marting, PharmD
			Fluad HD (2026-2027) 0.5 ml by Seqirus NDC: 70461-0026-03			Dan Winkelmann, RPh Other: _____

VIS and EUA Dates: Flu: 1/31/25 I Covid: 1/31/25 Tdap: 1/31/25 I Hep A: 1/31/25 I Hep B: 1/31/25 I Shingles: 2/4/22 I Men ACWY: 1/31/25 PCV: 5/29/25 I RSV: 1/31/25 I PPSV: 5/29/25