CVS pharmacy

Vaccine Administration Record

Immunization Type / Vaccine Name: COVID

Patient Information:

Last Name JIANG First Name XUEWEI Date of Birth 03/13/1993 Gender Female

Address 12421 SANFORD ST,LOS ANGELES,CA,90066

Phone (254) 214-9350

Primary Care Provider (PCP) Name

PCP Address City, State, Zip

Prescriber Name AZAD, ARMAGHAN

Prescriber Address 26520 CACTUS AVE, MORENO VALLEY, CA, 925553927

Store Information:

Store # 09493 Address 12315 VENICE BOULEVARD

RX # 1416304 00 City, State, Zip Mar vista,CA,90066 Telephone (310) 390-6296

Screening Questions:	YES	NO	N/A
1. Are you sick today? (For example: a cold, fever or acute illness)	☐	X	☐
2. Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) or have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital? If yes, what are you allergic to?	☐	X	☐
3. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	☐	X	☐
4. Do you have a bleeding disorder or take blood thinners such as Warfarin/Coumadin?	☐	X	☐

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Screening Questions:

		YES	NO	N/A
5.	Are you currently pregnant or breastfeeding or is there a chance you could become pregnant during the next month?		X	
6.	Have you ever had a severe allergic reaction after receiving another vaccine or injectable medication?		X	
7.	Have you ever had a severe allergic reaction after receiving Polyethylene Glycol?		X	
8.	Have you ever had a severe allergic reaction related to receiving Polysorbate or products containing Polysorbate?		X	
9.	Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?		X	
10.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart) either related to or unrelated to receipt of an mRNA COVID-19 vaccine?		X	

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Screening Questions:	YES	NO	N/A
11. Are you moderately/severely immunocompromised from a medical condition/immunosuppressive therapy, including/not limited to: active treatment for solid tumor/hematologic malignancy, solid organ/stem-cell transplant, primary immunodeficiency syndrome, advanced/untreated HIV infection, or active treatment with high dose corticosteroids/other immunosuppressive/ immunomodulatory biologic agents?		X	
12. Do you have a history of multisystem inflammatory syndrome (MIS-C or MIS-A)?		X	

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CONSENT FOR SERVICES: I have received/read (or had read to me) the Vaccine Information Statement(s), Vaccine Information Fact Sheet(s) and/or Patient Fact Sheet(s) regarding the vaccine(s). I understand the benefits/risks of vaccination. I voluntarily assume full responsibility for any reactions/consequences that may result. I understand I should remain in the vaccine administration area for 15 minutes, or longer if directed, after vaccination to be monitored for potential adverse reactions. In the event of side effects, I understand I should call the pharmacy, my doctor, or 911. I certify the information provided regarding eligibility for the vaccine is accurate and request the vaccine be given to me/the person previously named for whom I am authorized to make this request. If I am signing on behalf of another individual (including a minor), I attest I have the authority to do so. The following must have consent of a parent or guardian: Patients in Alabama/Nebraska under 19 yrs old; patients in South Carolina under 16 yrs old; and patients under 18 yrs old in all other states. If I am receiving a COVID-19 vaccine dose, I attest I am eligible for that dose according to current recommendations from the CDC. State of Georgia only: I verify a pharmacist asked for my health history and whether I had a physical exam in the past year. Health care providers did not identify conditions(s) that would mean I should not receive vaccine(s)

AUTHORIZATION TO REQUEST PAYMENT: I authorize CVS Pharmacy® (CVS®) to release information to Medicare, Medicaid or any other third party payer as needed and to request payment of authorized benefits to be made on my behalf to CVS, I certify the information provided about my Medicare, Medicaid or other coverage is correct

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: Notwithstanding anything previously set forth, I agree I am responsible for and will promptly pay on demand any and all obligations to CVS Pharmacy including all self-pay balances as well as charges for services not covered or disallowed by my insurance carrier (for non-COVID-19 vaccines)

DISCLOSURE OF RECORDS: I understand CVS® may be required to or may voluntarily disclose my health information with respect to this vaccine to my healthcare providers, my insurance plan, health systems and hospitals, and/or state or federal registries. I understand CVS will use and disclose my health information as set forth in the CVS Notice of Privacy Practices (copy is available in-store, online or by requesting a paper copy from the pharmacy team).. State of California only: I agree to have the California Immunization Registry (CAIR) share my immunization data with the health care providers, agencies or schools. State of Florida only: Students 18-23 may opt out of the immunization registry by notifying pharmacy prior to administration

X _____ Date: _____

Signature of patient to receive vaccine or person authorized to make the request (parent/guardian)

Vaccine Administration Information:

Administration Date 12/18/2023 | Vaccine MODERNA 2023-24 12 YR+ SYR | Manufacturer MODERNA US, INC

Lot # 3032679 | Exp. Date 05/30/2024 | Route IM | Site Left Deltoid

Volume (ml) 0.5 | VIS Version Date 10/18/2023 | Date VIS Given to Pt 12/18/2023

Verifying Pharmacist: Yee, Jessica

Yee, Jessica, Pharmacist

Administering Immunizer Name & Title