

Last Name LU

First Name YANXIN

Date of Birth 10/17/1989

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?

6. Have you ever had a severe allergic reaction after receiving another vaccine or injectable medication?

7. Have you ever had a severe allergic reaction after receiving Polyethylene Glycol?

8. Have you ever had a severe allergic reaction related to receiving Polysorbate or products containing Polysorbate?

9. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?

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?



Immunization Type / Vaccine Name: COVID

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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?

12. Do you have a history of multisystem inflammatory syndrome (MIS-C or MIS-A)?



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

Date: _____

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