

Last Name LU

First Name YANXIN

Date of Birth 10/17/1988

Screening Questions:

YES NO

5. Do you have a bleeding disorder or take blood thinners such as Warfarin/Coumadin?

6. For Tetanus vaccines, do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?

7. Are you currently pregnant or breastfeeding or is there a chance you could become pregnant during the next month?

U
mmunization Type / Vaccine Name: Tdap (Whooping Cough)

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INFORMED CONSENT FOR SERVICES: I have received and read (or had read to me) the Patient Fact Sheets and/or Vaccine Information Statements regarding the vaccine. I understand the benefits and risks of vaccination. I voluntarily assume full responsibility for any reactions or consequences that may result. I understand that I should remain in the vaccine administration area for 15 minutes, or longer if directed, after the 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 that the information provided regarding eligibility for the vaccine is accurate and request that the vaccine be given to me or to the person previously named for whom I am authorized to make this request. State of Georgia only: I verify a pharmacist asked for my health history and whether I have had a physical exam within the past year. Health care providers did not identify condition(s) that would mean I should not receive vaccine(s).

AUTHORIZATION TO REQUEST PAYMENT: I authorize CVS Pharmacy® (CVS®) to release medical 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 that the information provided about my Medicare, Medicaid or other coverage is correct.

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: Notwithstanding anything previously set forth, I agree that 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 those charges for services not covered or disallowed by my insurance carrier (For non-COVID-19 vaccines).

DISCLOSURE OF RECORDS: I understand that 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 that 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). State of California only: I agree to have the California Immunization Registry (CAIR) share my immunization data with health care providers, agencies or schools. State of FL 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 12/01/2023

Vaccine BOOSTRIX TDAP VACCINE
SYRINGE

Manufacturer GLAXOSMITHKLINE

Lot # 324B2

Exp. Date 01/30/2026

Route IM

Site Left Deltoid

Volume (ml) 0.5

VIS Version Date 03/31/2020

Date VIS Given to Pt 12/01/2023

Verifying Pharmacist: Bishehban, Parmis

Bishehban, Parmis, Pharmacist

Administering Immunizer Name & Title