COVID-19 Vaccination Voucher

Bring this voucher and a government-issued photo ID to the vaccination location.

Patient Information

Name: Jay Carter	**Gender:** M	**DOB:** May 27, 1992 (29 years)	**Initials:**
Address: 4524 Old Pine Trail		**City:** Delton MI 49046	**Phone:** 989-859-6343
Insurance Company Name: Blue Cross Blue Shield		**Member ID/Policy #:** XYE911770549	**Group #:** 007040967
Primary Care Physician Name: Dr. Craig Sonke		**Primary Care Physician Phone #:** 9898398810	
Race: White	**Ethnicity:** Hispanic/Latino	**Eligibility:** 18-64 risk of COVID-19 exposure and transmission	
Vaccine requested: Covid Pfizer-BioNTech		**Dose type:** Booster	
First dose: 1/4/2021 (Pfizer-BioNTech)		**Second dose:** 1/25/2021 (Pfizer-BioNTech)	

Questions below will help us determine your eligibility to be vaccinated today. DK = Don't Know

1. Are you sick or do you have a fever?	YES	NO	
2. Have you had a severe allergic reaction to food, pet, venom, environmental or oral medication?	YES	NO	
3. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	YES	NO	DK
4. Have you had an allergic reaction to polyethylene glycol (PEG), polysorbate or a previous dose of COVID-19 vaccine?	YES	NO	DK
5. Are you a male between ages 12 and 29 years old?	YES	NO	
6. Do you have a history of myocarditis or pericarditis?	YES	NO	
7. Do you have a history of Guillain-Barré syndrome (GBS)?	YES	NO	
8. Are you a female between ages 18 and 49 years old?	YES	NO	
9. Do you have a history of heparin-induced thrombocytopenia (HIT)?	YES	NO	
10. Do you have a bleeding disorder or are you on a blood thinner?	YES	NO	
11. Are you currently pregnant or breastfeeding?	YES	NO	
12. Do you have a history of using a dermal filler?	YES	NO	
13. Do you have a weakened immune system (ie. HIV infection, cancer) or take immunosuppressive drugs/therapies?	YES	NO	
14. Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?	YES	NO	
15. Have you had COVID-19 and were treated with monoclonal antibodies or convalescent serum?	YES	NO	

Appointment Information

Appointment Date:	**Appointment Time:**	**Location:**	**Voucher #:**
Nov 22, 2021	12:30 PM	Family Fare 902 W. State St., Hastings MI 49058	71467481

Please bring an identification card to your appointment, if you have one.

I hereby certify that the above information I provided is true and correct to the best of my knowledge.

Patient/Legal Guardian Name:_____ Signature:_____ Date:_____

The following is to be completed by the health care provider ONLY.

Vaccine Administrator Name (Print):	Professional Designation:	Signature:
Intern Name (Print):	Administration Date/Date Fact Sheet/Immunization Card Given:	

Vaccine	Lot #	Exp. Date	Manufacturer	NDC	Dose #	Dosage mL	Site	Route	RPh Init.
			Pfizer-BioNTech				LA RA	IM	
			Moderna				LA RA	IM	
			Janssen				LA RA	IM	