STAR WELLNESS® USA

On-site Medical Screening & Laboratory Services
451 Westpark Way, Suite 1 ★ Euless, TX 76040
817-571-6425 or 1-800-685-5572

VACCINATION DOCUMENTATION & CONSENT

INFORMATION ABOUT PERSON TO RECEIVE SHOT - ***please PRINT LEGIBLY:***

LAST NAME:	LEGAL FIRST NAME:	Sex: M F	Patient Date of Birth: MM/DD/YYYY - -
Organization where shot received: Office	Home Address:	City: , TX	Zip:
COUNTY: (Circle) Ellis | Wise | Parker Kaufman | Rockwall | Collin | Dallas Denton |Tarrant | Johnson | Hood | Hunt Other:	Race: ☐ White ☐ Black ☐ Asian ☐ Am Indian/Alaskan ☐ Refused ☐ Hawaiian/Pac Island ☐ Other	Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	CELL PHONE: ( ) -

Please answer the following questions for the person being vaccinated:

1. Have you been exposed or tested **POSITIVE** for Covid-19 in the past 14 days? YES NO
2. Are you having any trouble breathing, or experiencing **loss of taste & smell**? YES NO
3. Have you ever had a **severe allergic reaction** (requiring epinephrine) to a vaccine? YES NO
4. Are you **pregnant**, nursing, on chemotherapy or immunosuppressants? YES NO
5. Have you ever been diagnosed with a **low platelet count**, or a **bleeding disorder**? YES NO
6. Are you allergic to eggs, have taken antibiotics, or had a fever in the past 3 days? YES NO
7. Have you ever had Guillain-Barre' syndrome? YES NO

I have had the opportunity to review the HIPAA Privacy Notice and Vaccine Information Statements (VIS) & FACT Sheets for the injections I have selected to receive today. I know and understand the benefits and risks of the vaccine, have had the opportunity to ask questions about the vaccine, voluntarily give my signed permission, and request the personnel of Star Wellness® to administer the shots selected below to me. I hereby ***FULLY ASSUME THE RISK*** *for injury or loss which I may sustain as a result of these injections and* ***RELEASE*** *my employer, the person administering my injection, Star Wellness®, van Eeden, LLC, its employees and contractors, as well as other organizations associated with these injections from all liability, claims, demands, and causes of action,* ***INCLUDING THOSE BASED ON NEGLIGENCE OR FAULT****, arising from or in any way connected with the injections I have selected to receive. I authorize the release of any medical or other information necessary to process the claim for the administration of this vaccination and request payment directly to Star Wellness® for administration services rendered today.* ***I certify that the information I have provided here is correct and attest that I meet the current ACIP/CDC eligibility requirements if requesting to receive a third dose or booster of COVID-19 vaccine today.***

X _____

SIGNATURE *Email* *DATE*

For office use only:

PRIMARY Ins. ID (or DL# if no Insurance; SSN if no Medicare card): Aetna | BCBS | Cigna | Humana S&W | UHC | UMR | Medicare Meritain | NONE	Payor ID (if not listed):	**Mother's FIRST NAME** (for ImmTrac2 reporting)	
Relation to insured: 18-self | 01-sp | 19-ch	Insured Name (if not patient):	Insured Sex: M F	Insured Date of Birth: MM/DD/YYYY - -

Date.	Had Before?	Vaccine	Type/Dose #	CPT	Site	Lot#	Tech Int
	Yes / No	J&J	#1 / #2	0031A/0034A	LUE RUE	211A21A / 1822811	
	/	Pfizer	#1 #2 #3 B	01A/02A/03A/04A	LUE RUE	FE3592 / FG3527	
	Yes / No	Flucelvax®	MDV / PFS	90756 / 90674	LUE RUE	309615	
	/	Moderna	#1 #2 #3 B	0011A/12A/13A/64A	LUE RUE	939906	
	Yes / No	Afluria MDV	MDV / PFS	90688 / 90686	LUE RUE	P100353149	
		B12 / Lipo		N/A	LUE RUE LLE RLE		
	Last:	TDAP	PFS	90715	LUE RUE	57GJ2	

#1 Billed: _____ IMM: _____ Paid: _____ #2 Billed: _____ IMM: _____ Paid: _____