



<b>Family Care/Cedarfield Pharmacy COVID 19 2021-2022 Consent Form</b>		<input checked="" type="checkbox"/> COVID 19 <input type="checkbox"/>		Payment abbreviation (circle one) CASH    CHK    INS	
Please print all information below:					
1. Last Name		2. First Name		3. Mid. Initial	4. <input type="checkbox"/> Male <input type="checkbox"/> Female
5. Address		6. City	7. State	8. Zip code	9. County
10. Telephone Number (including area code)			11. Birth Date (month/day/year)		12. Age
13. Medicare number as it appears on your card. Include numbers and letter(s).					
14a. Other insurance provider			14b. Other insurance ID number as it appears on your card		
15. Primary Care Provider's Name			16. Primary Care Provider's Phone Number		

**PLEASE READ CAREFULLY:** I understand I will be provided an Emergency Use Authorization Fact Sheet or a Vaccine Information Statement prior to the date of vaccination and have the ability to revoke consent at any time.

Signature of person to receive vaccine, or person authorized to make request:  
 X \_\_\_\_\_

**\*\*Clinic Use Only-Do Not Write Below This Line\*\***

Vaccine	Date Given	Manufacturer (Circle One)	Lot Number	Expiration Date	Site	Route	(Circle One) Dose	Clinic Site	Administered By
Dose #1		Moderna Pfizer J & J			RD    LD	IM	0.3cc 0.5cc	Auburn Hills	
Dose #2		Moderna Pfizer J & J			RD    LD	IM	0.5cc		
Dose #3 Booster		Moderna Pfizer J & J			RD    LD	IM	0.5cc	Auburn Hills	