Sid's Pharmacy

Vaccination Administration Form

_____ _____/_____/_____

First Name M.I Last Name ☐ M or ☐ F Date of Birth (MM/DD/YYYY)

_____ _____

Full Street Address (PO Box acceptable if given with physical address) Phone

ALLERGIES: ☐ No Known Allergies ☐ **EGGS** ☐ **LATEX** ☐ Penicillin ☐ Sulfa ☐ Erythromycin ☐ Other: _____ (neomycin, gentamycin, bovine protein, gelatin, thimerosal, phenol or yeast)

MEDICAL CONDITIONS: ☐ No Known Medical Conditions ☐ High Blood Pressure ☐ Diabetes ☐ High Cholesterol ☐ Asthma ☐ Arthritis ☐ Depression ☐ Pregnancy (Due:_____) ☐ Other:_____

Did you receive a flu shot last year? ☐ YES ☐ NO /PRIMARY Care Doctor or Clinic_____

I have received the current vaccine information sheet. I have had the chance to ask questions and they were answered to my satisfaction. I understand the benefits/risk of the vaccine and ask that it is given to me or the person named above for whom I am authorized to make this request. I also received the Notice of Privacy Practices.

_____ _____

Signature **Date (MM/DD/YYYY)**

INSURANCE / MEDICARE INFORMATION

Please present ALL Insurance Cards: Pharmacy-Copy and attach to form

Medicare# (B Coverage)_____ Other_____

I am aware of the pharmacy's policy that billing my insurance/Medicare on my behalf is a courtesy provided by them and that I am responsible for any deductible or co-insurance amounts. I understand that Medicare may pay part of the amount billed by the pharmacy or part of Medicare allowable amount whichever is less and that I am responsible for the remaining amount. I understand that if any of my claims are rejected by my insurance/Medicare, I will pay the pharmacy for the full amount of the claim. I recognize my obligation to forward payment to the pharmacy for any payment received by me due to them.

INSURANCE LIFE-TIME AUTHORIZATION

I request payment under the medical insurance program be made to me or the pharmacy named above on any bills for service. I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for the claim or any related Medicare claim. I further permit a copy of this authorization to be used in the place of the original.

Patient's Signature:_____

Influenza: ☐ **Regular** ☐ **High Dose (>=65)** ☐ **for Egg allergy**

Other: ☐ **Prevnar 20** ☐ **Hepatitis A** ☐ **TDAP** ☐ **Shingrix** ☐ **HPV** ☐ **Hepatitis B** ☐ **_____**

---------- Pharmacy Use Only Below ----------

Patient and Pharmacist have reviewed checklist thoroughly and all questions have been answered.

Date of Vaccination ___/___ / ____ Pharmacist Signature: _____

Screening Checklist or Contraindications to Vaccines for Adults

For Patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Yes No

☐ ☐ Are you sick today?

☐ ☐ Do you have allergies to medications, food, a vaccine component, or latex?

- ☐ Have you ever had a serious reaction after receiving a vaccination?
- ☐ Have you had a seizure, brain or other nervous system problem?