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

PLEASE READ OVER SCREENING CHECK LIST CAREFULLY WITH THE PHARMACIST (See reverse side)

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:_____
If for some reasons, the patient is mentally or physically unable to sign the form, the signature of a relative, friend, legal guardian, representative payee, or the representative of any institution providing care is acceptable. The name of the patient should be shown on the signature line followed with "BY" and the signature and address of the individual signing for the patient. The mental or physical problem, which does not allow the patient to sign, and the relationship of the person signing on their behalf, must be also be indicated on this form. A physician or supplier's office cannot sign on behalf of a patient except under extraordinary circumstances. Please contact the Medicare Office if you need further details.

Influenza: □Quadrivalent □High Dose (65>)
Other: □Prevnar 13 □Pneumovax 23 □TDAP □Shingrix □Zostavax □Hepatitis B
□_____

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

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

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

Vaccine Label	Site of Injection	VIS Date

Sid's Pharmacy

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?

☐ ☐ Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. , diabetes, anemia, or other blood disorder?

☐ ☐ Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?

☐ ☐ In the past 3 months, have you taken medications that affect your immune system such as prednisone or other steroids? Have you taken medication for cancer, rheumatoid arthritis, Crohn's disease or psoriasis? Have you had radiation treatments?

☐ ☐ Have you had a seizure, brain or other nervous system problem?

☐ ☐ During the past year, have you received a transfusion of blood, blood Products, been given immune (gamma) globulin or an antiviral drug?

☐ ☐ For women: Are you pregnant or is there a chance you could become pregnant during the next month?

☐ ☐ Have you received any vaccinations in the past 4 weeks?

□ □ Have you had surgery in the past 2 months?

THANK YOU

PHARMACIST
PLACE RX LABEL
HERE