Flu

Vaccine Administration Record

Section A

First Name: ____________________ Last Name: ____________________

DOB: __________ Age: _____ Gender: M F Phone: ____________________

Address: ______________________________ City: __________ State: _____ ZIP: _______

Insurance Provider and ID: ______________________________

BIN: __________ PCN: __________ Group: __________

Central Pharmacy will send immunization information to the physician(s) you provide below:

Physician name: ____________________ Physician Phone: ____________________

Physician address (city): ____________________ State: __________ ZIP: __________

Section B The following questions will help us determine which vaccines you may be given today.

		YES	NO	DON'T KNOW
1.	Are you sick today?	☐	☐	☐
2.	Do you have any allergies to medications, food, latex, or a vaccine component?	☐	☐	☐
3.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4.	Do you have a long-term health problem such as heart disease, lung disease, asthma, kidney disease, diabetes, a blood disorder?	☐	☐	☐
5.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6.	In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, anticancer drugs, drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis, or had radiation treatments?	☐	☐	☐
7.	Have you had a seizure disorder, brain disorder, Guillain-Barrè Syndrome, or other nervous system problem?	☐	☐	☐
8.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10.	Have you received any vaccinations in the past four weeks?	☐	☐	☐

Section C I authorize the release of any medical or other information related to this vaccine to my healthcare providers, Medicare, Medicaid, or other third-party payer as needed and request payment of authorized benefits on my behalf to Central Pharmacy.

I acknowledge that if my insurance does not cover cost of administering the vaccine, then I am responsible for payment. I acknowledge that my vaccination record may be shared with city, state, or federal agencies for registry reporting, and that administration of an immunization does not substitute for an annual check-up with a physician.

I acknowledge receipt of Central Pharmacy's Notice of Privacy Practices for Protected Health Information, and that the pharmacist recommends vaccinated patients should remain in the waiting area for 20 minutes after administration of the immunization.

I have reviewed the Vaccine Information Sheet (VIS) regarding the vaccine(s) and have had the opportunity to ask questions that were answered to my satisfaction, and understand the benefits and risks of vaccines. I fully release and discharge Central Pharmacy-LLC, its affiliates, owners, and employees from any liability for illness, loss, or damage which may result.

I acknowledge the receipt of vaccine(s) administered on behalf of the patient listed and have been offered counseling on these same vaccine(s).

Patient signature: ______________________________ Date: __________

Section D PHARMACY USE ONLY

Influenza	Meningococcal	Other:
Pneumococcal	HPV	Other:
Zoster	Varicella	MMR
Hepatitis B	Hepatitis A	Hepatitis A & B
Tdap	DTaP	Td

Place RX Label Here

Lot #: ______________
Exp. Date: ______________
Site: RA or LA

Place RX Label Here

Lot #: ______________
Exp. Date: ______________
Site: RA or LA

Pharmacist Name: ______________________________