Pharmacy Name: BLANDON PHARMACY Patient Name: _____
Pharmacist: _____ DOB: _____
Location: BLANDON, PA Today's Date: _____

VACCINE ADMINISTRATION RECORD, SCREENING and PATIENT CONSENT

1. Have you ever had a severe reaction to any vaccine that required medical care? ☐ YES ☐ NO
   If yes, describe:_____
2. Do you have any allergies to food, medications or vaccines? ☐ YES ☐ NO
3. Are you sick today? ☐ YES ☐ NO
4. Have you had Guillain-Barre Syndrome, seizure, brain or nerve problems? ☐ YES ☐ NO
5. Are you pregnant or planning on becoming pregnant in the next 3 months? ☐ YES ☐ NO
6. Are you or anyone in your household being treated with chemotherapy or radiation for cancer, have HIV/AIDS or any immune deficiency disorder? ☐ YES ☐ NO
7. Do you or anyone in your household take oral prednisone (>20mg/day) or other oral steroids or anticancer drugs? ☐ YES ☐ NO
8. Do you have a bleeding disorder or take "blood thinners" like Coumadin or Heparin? ☐ YES ☐ NO

The following questions will help determine any other indications or contraindications.

1. What adult vaccinations has this patient received (vaccine and date)? _____
2. List all Rx and OTC medications this patient is currently taking:_____
3. List all current medical conditions:_____
4. List all know allergies:_____

INFORMATION ABOUT PERSON TO RECEIVE VACCINE *(please print)*

Name Last	First	Middle Initial	Social Security #
Address	City	State/Zip	Phone#
Select One			
Birthdate Sex	Physician		Physician Phone or Fax

I authorize this information to be sent to the physician's office specified above. ☐ YES ☐ NO
Failure to check a box shall result in the patients' vaccine documentation to be sent to physician office above.

Please read the following statements and sign below on the signature line.
I have read or have had explained the information provided about the vaccine I am to receive. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of vaccination and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. Medicare, I do hereby authorize the *above Pharmacy* to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

X Date:
Signature of person to receive vaccine or person authorized to make the request (parent or guardian)

DO NOT WRITE BELOW THIS LINE – For Pharmacy Use Only

VACCINE	LOT#	EXP DATE	MANUFACTURER	DOSE (mL)	ADMINISTRATOR	VIS DATE	SITE OF ADMINISTRATION

X Date:
Signature of Pharmacist administering vaccine(s).