VACCINE FORM

Patient Name: _____ M: ☐ F: ☐

DOB: _____ Age:_____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Information: Do you have insurance? Yes No On File

ID or Medicare #: _____

RxGroup: _____

RxPCN: RxBIN:

If "No", Please fill in one of the following:

Drivers License #:_____

State ID#: SSN:

Which vaccines would you like today: (Check all that apply)

Covid-19:	J&J: 1st Booster	Pfizer: 1st 2nd Booster	Moderna: 1st 2nd Booster

Influenza Vaccine: Flu Vaccine	**Pneumonia:** Prevnar 20 Pneumovax 23
Shingles: Shingrix 1st Booster	**Tetanus/Diphtheria/Pertussis:** Adacel
Other Vaccine:	

Screening Questionnaire

Have you received the vaccine(s) before?	☐ Yes	☐ No	☐ Unknown
Have you ever had a severe reaction to any vaccine(s)?	☐ Yes	☐ No	☐ Unknown
Are you allergic to latex, eggs, baker's yeast, Streptomycin or Neomycin?	☐ Yes	☐ No	☐ Unknown
Do you currently have a fever, diarrhea or vomiting?	☐ Yes	☐ No	☐ Unknown
Are you or anyone in your home taking immunosuppression? (Cancer, HIV / AIDS or any disease that affects the immune system)	☐ Yes	☐ No	☐ Unknown
Have you had any blood or blood products in the past year?	☐ Yes	☐ No	☐ Unknown
Are you pregnant or planning on pregnancy in the next 3 months?	☐ Yes	☐ No	☐ Unknown
Are there any unresolved health concerns we need to be aware of?	☐ Yes	☐ No	☐ Unknown

I, the undersigned, have read or had explained to me the vaccine information sheet (VIS). I understand the risks and benefits associated with the selected vaccine and have had any questions satisfactorily answered. I voluntarily request that the vaccine be given to me or for the aforementioned person for whom I am authorized to make this request.

_____ _____

Signature Date

For Office Use Only

Date Given:		Manufacturer & Lot:	
		Expiration Date:	

Route: IM ☐ SQ ☐ ID ☐ IN ☐ Site: RT ☐ LT ☐ RD ☐ LD ☐ RThigh ☐ LThigh ☐

Administered By:_____