First: _____ Last: _____

Vaccination Intake Form (patient's authorization and VAR)

Section 1: Patient information

First Name: _____ Last: _____ Today's date: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ Email address: _____

Birthdate: _____ Age: _____ Gender: _____

Section 2: Insurance

Insurance Company Name: _____ BIN Number: _____

Member ID #_____Group Number: _____

Section 3: Screening Questionnaire

1. Is the person to be vaccinated sick today? **Yes / No**

2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? **Yes / No**

3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? **Yes / No**

4. Has the person to be vaccinated ever had Guillain-Barré syndrome? **Yes / No**

5. Do you have any health conditions such as: heart disease, diabetes or asthma? **Yes / No**

If Yes Please list: _____

6. **For Women:** Are you pregnant or considering of becoming pregnant in the month? **Yes / No**

Live Vaccines (Flu nasal spray, Shingles, MMR, Yellow Fever, Oral Typhoid an Chickenpox)

7. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past three months, have they taken medications that affect the immune system, such as prednisone, other steroids, drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis or anticancer drugs; or have they had radiation treatments? **Yes / No**

If yes please list: _____

8. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)? **Yes / No**

9. Is the person to be vaccinated a child or teen age 2 through 17 years and receiving aspirin therapy or aspirin-containing therapy? **Yes / No**

10. Do you have a nasal condition serious enough to make breathing difficult**? (nasal vaccine only) YES/No**

First: _____ Last: _____

Vaccination Intake Form (patient's authorization and VAR)

Section 4: Patient consent and signature

I GIVE CONSENT to the P&M Pharmacy and its staff to vaccinate me with the requested vaccine. I FULLY UNDERSTAND THAT I WILL BE ULTIMATELY RESPONSIBLE FOR ANY CHARGES if I am not a covered person under the insurance plan (program listed above), the services are not covered services, or any co-pays, deductibles or coinsurance obligations apply.

Signature: _____ Date of Service: _____

Vaccine (S) Requested: _____

VIS Documentation: I received Vaccine Information Statement _____ (Please sign)

Please send my immunization information to my Doctor. Yes/No

Doctor's name: _____ Phone number: _____

To be Completed by Immunizer

Section 5: Vaccination record

Vaccine	NDC / Manufacturer	Lot number/ Expiration date	Dosage	Site of administration	Administration Date

Pharmacist name (Print): _____ Pharmacist Signature: _____

Vaccine _____ VIS Published Date: _____ Date VIS given to patient: _____

Vaccine _____ VIS Published Date: _____ Date VIS given to patient: _____