Poole's Pharmacy Care

Immunization Form

Patient Name: _____ Date of Birth: ___/____/_____

Address: _____City_____

Family Doctor or Nurse Practitioner's Name:_____

Email:_____ Patient Cell #:_____

Place of Employment:_____ Business Phone#:_____

Screening Questionnaire for Adult Immunization	Yes	No	N/A
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 such as heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?			
Do you have cancer, leukemia, AIDS, or any other immune system problem?			
Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?			
Have you had a seizure or brain or other nervous system problem?			
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or antiviral drug?			
For women: Are you pregnant or is there a chance you could become pregnant during the next month?			
Have you ever fainted after receiving an immunization before?			
Have you received any vaccinations in the past 4 weeks?			

Insurance Information: Insurance Carrier Name:_____

Cardholder Name:_____ Cardholder DOB:____/_____/_____ ID #:_____

Rx Group #:_____ BIN #:_____ PCN #:_____

I have been given the most recently updated copy of the U.S. Public Health Service Vaccination Information Statement(s) (VIS) for the following immunizations: ☐ Influenza Vaccine ☐ Pneumococcal Vaccine ☐ Hepatitis A & B Vaccine ☐ Shingles Vaccine ☐ Tdap Vaccine ☐ Meningococcal Vaccine ☐ Other_____. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the risks and the benefits of the vaccine(s) and request that it be given to the person named above and for whom I am authorized to make this request.

Do you have a Vaccination Administration Record or Card with you? ☐ Yes ☐ No

Signature: _____ **Date:**____/_____/_____

**If Pharmacy Insurance does not cover vaccination, then we will call you for Medical Insurance information.

For Office Use Only: Vaccinations Administered:

☐Influenza _____ Mfg: _____ Lot:_____ _____ Site: _____

☐Pneumococcal _____ Mfg: _____ Lot: _____ Site: _____

☐Hepatitis A&B _____ Mfg: _____ Lot: _____ Site:_____ _____

☐Shingles _____ Mfg: _____ _____Lot: _____ Site: _____

☐Tdap _____ Mfg: _____ Lot:_____ _____ Site: _____

☐Meningococcal _____ Mfg: _____ Lot: _____ Site: _____

☐Other _____ Mfg: _____ _____Lot: _____ Site: _____

Date of Vaccination: _____/_____/_____ Name of Vaccinator_____

Poole's Pharmacy Care Reviewing Agent Signature:_____