VACCINE ADMINISTRATION RECORD

PATIENT: Please complete the following

Print Name: _____ Male / Female Age: _____

Home Street Address: _____DOB:_____/_____/_____

City: _____ State: _____ Zip: _____ Phone: _____

E-mail address: _____

Have you ever used River Road or Creswell Health Mart Pharmacy? □ Yes □ No
Did you know we offer FREE prescription delivery to your home or work? □ Yes □ No
Did you know we have a compounding department? □ Yes □ No
Would you be interested in transferring your current RXs to us? □ Yes □ No

Vaccination Requested: (please check ALL that apply):
□Flu (seasonal) □Shingles □Pneumonia □Chicken Pox □Hib □Meningitis

□Hepatitis A □Hepatitis B □Hepatitis A+B □Human Papillomavirus (HPV)

□Measles/Mumps/Rubella □Tetanus/Diptheria □Tetanus/Diptheria/Whooping Cough

Please circle answers:

Are you feeling ill or do you have a fever?	Yes	No
Have you had a severe reaction to a previous vaccination?	Yes	No
Do you have any allergies to any food, medicines or vaccines?	Yes	No
List allergies: _____		
For women: Are you pregnant or planning to become pregnant soon?	Yes	No
Do you or anyone you are in direct contact with have cancer, AIDS, Leukemia, or any other immune disease?	Yes	No
Are you currently being treated for any chronic diseases such as heart disease, asthma, seizures or diabetes?	Yes	No
Have you received any vaccinations recently or are you planning on receiving any other vaccinations within 4 weeks?	Yes	No
Have you been the recipient of any transfusions, blood products, or been given medicine called immune (gamma) globulin within the last year?	Yes	No

Vaccine administration consent: "I have received the Vaccine Information Statement and have read or have had explained to me the information in that sheet. I have had a chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine. I understand that some or all of the information on this vaccination record is required by law to be reported to the Oregon ALERT Immunization Information System. I request and authorize the pharmacist to administer the vaccine to me."

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

(for pharmacy use)

Right / Left
IM / SC

Lot#: _____
Exp#: _____
VIS: _____
Look up in ALERT ___Y ___N
Other Vaccines recommended _____
Date reported to ALERT: _____/_____/_____

Insurance:

BIN: PCN:
ID: member #
Group #
Insurance phone #