Clinic Name: ____________________ DOB: _____/_____/______

IMMUNIZATION ADMINISTRATION RECORD

PATIENT: Please complete the following

Print Name:															
Home Street Address:															
City, State, Zip Code															
Phone:											Age:				

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 □ Tetanus/Diphtheria/Whooping Cough

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

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:** _____/_____/_______

Parent or legal guardian signature/date: ____

Revised 4/22/2019

(for pharmacy **use)**

Right / Left
IM / SC
Lot#: __ ______________________
Exp# ID: ______________________
VIS: _________________________

Insurance:
ID#
Group #
BIN:
PCN:
Person Code:

IPTF

☐ Bill insurance
☐ Invoice company
☐ Invoice individual

NP ______________