VACCINE ADMINISTRATION

Patient Name:	Phone:	Sex: M / F
Street:	DOB:	Race:
City:	St:	Zip:

RSV VACCINE		SHINGLES		HEP A		MMR	
COVID		FLU		HEP B			
PNEUMONIA		TDAP		TETANUS			

Fever? Yes or No Exposure? Yes or No Symptoms? Yes or No			
Please circle which are you would like the vaccine administered:	Left	Right	
Are you feeling sick today?	Yes	No	Unk
Have you tested positive for COVID-19? If so, what date: _____	Yes	No	Unk
Do you have allergies to medications, food, latex, or vaccine component?	Yes	No	Unk
Have you ever had a serious reaction after receiving a vaccination?	Yes	No	Unk
Have you ever had Guillain-Barre´ Syndrome?	Yes	No	Unk
Do you have any long-term health problems with heart, kidney and/or lung disease, asthma, metabolic disease (e.g. diabetes, anemia or other blood disorder?	Yes	No	Unk
Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?	Yes	No	Unk
In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, other steroids anti-cancer drugs, or have you had radiation treatment?	Yes	No	Unk
Have you had a seizure, or brain or other nervous system problem?	Yes	No	Unk
During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?	Yes	No	Unk
Women: Are you pregnant or is there a chance you could be during the next month?	Yes	No	Unk
Have you received any vaccinations in the past 4 weeks?	Yes	No	Unk
Have you ever received a shingles vaccine?	Yes	No	Unk
Have you had a pneumonia vaccine within the past five years?	Yes	No	Unk

Signature of Patient or Legal Guardian: _____ Date: _____

Print Name: _____. Relationship: _____

IF YOUR INSURANCE DOES NOT COVER YOUR SHOT OR INSURANCE IS NOT PROVIDED, YOU WILL BE CHARGED/INVOICED AT THE MEDICARE REIMBURSEMENT RATE.

ENSURE WE HAVE THE CORRECT INSURANCE AND CONTACT INFO TO MINIMIZE RISK.

MEDICARE NUMBER: **RX BIN NUMBER:**

PLEASE HAVE COPIES OF ALL OF YOUR INSURANCE CARDS PREPARED FOR OUR STAFF. MOST IMPORTANTLY YOUR RED/WHITE/BLUE MEDICARE CARD, IF APPLICABLE