Vaccine Administration Record and Consent

Name: _____ DOB: ___/___/_____ Gender: M/F Phone Number: (___)____-_____

Address: _____ City:_____ State: _____ ZIP: _____

Food/Drug Allergies: _____ Primary Care Physician/Address: _____

Medicare Part B: Y/N Vaccination requested_____

Screening Questionnaire for Immunizations
Please place an X in the box to help determine if the vaccine(s) may be given today

	YES	NO	Explain
1. Are you sick today? (Do you have fever, diarrhea or have you vomited?)			
2. Have you ever had a severe reaction to any vaccine?			
3. Are you allergic to eggs, thimerosal, Streptomycin, or neomycin?			
4. For women: Are you pregnant or is there a chance you could become pregnant in the next month?			
5. Have you had a seizure or a brain disorder or other nervous system problem?			
6. Do you have Guillain-Barre syndrome? (a condition that causes paralysis)			
7. Do you have any other chronic health conditions like asthma or diabetes?			
8. Have you had a pneumococcal vaccine? (pneumonia shot)			

I have read, or have had explained to me the information regarding the vaccine(s) marked below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risk of the vaccine(s) being administered and authorize the administration of the vaccine to me or the person name below for whom I am authorized to make this decision.
I, for myself, my heirs, and executors release ADAMS DRUGS, as the Medicare/private insurance provider, any retail or external site, physician, and employees, from any and all claims arising out of, or in any way related to my receipt of this or these immunization(s). ADAMS DRUGS and the aforementioned related parties shall not at any time or any extent be liable or responsible for any loss, injury, death, or damage to be suffered or sustained at any time as a result of this vaccination program.
I consent the release of this information to my Primary Care Physician as listed above to document receipt of vaccination.
I agree to wait in the designated vaccination area for approximately 20 minutes for observation after vaccination.

I authorize ADAMS DRUGS to release information and request payment from my insurance company/Medicare. I certify that the information given by me in applying for payment under my insurance provider is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf to Adams Drugs/or my Medicare Part B provider.

Signature: _____ Date: _____

For Pharmacy Use Only:

Vaccine	MFG	Quantity (mL)	Lot	Exp	Route/Site	Date Given	Date NOV sent to PCP

Vaccine Administered by: _____ Date: _____ Location: _____

Vaccinations given pursuant to the standing orders signed by Dr. Chai Chamnong

Updated on 09-23-2019

Please place prescription back tag here.