PATIENT IMMUNIZATION ADMINISTRATION

Patient Name: ____ DOB: _____/_____/_____

Patient Signature: ____

Parent Name (if under 18): __________________________ Parent Signature: __________________________

Emergency Contact Name:_________________ Phone #: __________

Insurance Information (Required):

RX BIN	
RX PCN	
PT ID #	
RX GROUP #	
PERSON CODE (IF LISTED)	

	Yes	No	Don't Know
1. Please circle which arm you would like the vaccine administered **LEFT ARM** **RIGHT ARM**			
2. Are you sick today?			
3. Do you have allergies to medications, food, latex or vaccine component?			
4. Have you ever had a serious reaction after receiving a vaccination?			
5. Have you ever had Guillain Barre Syndrome?			
6. 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?			
7. Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?			
8. 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?			
9. Have you had a seizure or brain or other nervous system problem?			
10. During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?			
11. Women: Are you pregnant or is there a chance you could be pregnant during the next month?			
12. Have you received any vaccinations in the past 4 weeks?			
13. Have you ever received a shingles vaccine?			
14. Have you had a pneumonia vaccine within the past five years?			

For Pharmacists Use Only: Lot:____________ Exp:__________

Route: **IM** **SQ** Location Administered: __________

Administering Pharmacist:______________________