Lynn Oaks Compounding Pharmacy

VACCINE ADMINISTRATION RECORD, SCREENING AND PATIENT CONSENT

SECTION A: Information about person to receive vaccine (please print)

Name (Last, First, Middle Initial)	**Date of Birth** (mm/dd/yyyy)	**Gender** ☐ Male ☐ Female

Address	**City**	**State**	**Zip Code**	**Phone Number** ( )

SECTION B: The following questions will help determine which vaccine(s) may be given today. For all vaccines: Please answer questions 1-6. For live vaccines (i.e. Zostavax): Please answer questions 1-10.		**YES**	**NO**
ALL VACCINES	1. Are you sick today?	☐	☐
	2. Do you have any allergies to food, medications or vaccines?	☐	☐
	3. Have you ever had a severe reaction to any vaccine that required medical care? **If yes, please describe:**	☐	☐
	4. Have you received any vaccinations in the past 4 weeks? **If yes, please list:**	☐	☐
	5. Have you had Guillain-Barre Syndrome, seizure, brain, or nerve problems?	☐	☐
	6. Are you pregnant or planning to become pregnant in the next month?	☐	☐
LIVE	7. Are you or anyone in your household being treated with chemotherapy or radiation for cancer, have HIV/AIDS or any immune deficiency disorder?	☐	☐
	8. Do you or anyone in your household take oral prednisone (>20 mg/day) or other oral steroids, or anticancer drugs?	☐	☐
	9. Do you have a bleeding disorder or take "blood thinners" like Coumadin or heparin?	☐	☐
	10. During the past year, have you received a transfusion of blood or blood products or been given a medicine called immune (gamma) globulin?	☐	☐

1. List all prescription and OTC medications you are currently taking:

2. List all current medical conditions:

SECTION C: Please read the following statements and sign below on the signature line.

I have read or have had explained the information provided about the vaccine I am about to receive. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of vaccination and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

Medicare beneficiaries only: Medicare, I do hereby authorize Lynn Oaks Compounding Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I request that payment of authorized benefits be made on my behalf.

PATIENT SIGNATURE - Person to receive vaccine or person authorized to sign on the patient's behalf	**Date Signed**
X	

SECTION D: DO NOT WRITE BELOW THIS LINE - FOR PHARMACY ONLY

VACCINE	LOT #	EXP DATE	MANUFACTURER	DOSE (ml)	VIS DATE	ROUTE	ADMIN. SITE

*__Routes__: IM = intramuscular, SC = subcutaneous, IN = intranasal *__Admin. Sites__: RA = right arm, LA = left arm, RT = right thigh, LT = left thigh

PHARMACIST SIGNATURE	**Date Vaccine Administered**
X	