LOCKWOOD
PHARMACY

10801 Lockwood Dr. suite 190

Silver Spring, MD 20901

Patient name: _____ Date: _____

Please read questions below. Indicate Yes or No for the person receiving a vaccine today.

| | Yes | No |
|---|---|---|
| 1. Has this person ever had a sever reaction to any vaccine, which required medical care? | ------ | ------ |
| 2. Is this person allergic to egg, baker's yeast, streptomycin or neomycin? | ------ | ------ |
| 3. Does this person have fever, diarrhea or vomiting today? | ------ | ------ |
| 4. Is this person or anyone in the home being treated with chemotherapy, radiation for cancer, have HIV/AIDS, or any immune deficiency disease? | ------ | ------ |
| 5. Is this person receiving treatment for any disease or illness? | ------ | ------ |
| 6. Do you want to inform your doctor about today's vaccination(s) | ------ | ------ |

If yes, please provide the following doctor's info:

- Name:
- Tel:
- Fax:

| | | |
|---|---|---|
| 7. Has this person had immune globulin or blood transfusion in the past year? | ------ | ------ |

If yes, when?

| | | |
|---|---|---|
| 8. Is this person pregnant, or planning to get pregnant in the next three months | ------ | ------ |
| 9. Please, list all prescriptions or over the counter medications that this person is currently taking | ---------- | |

---

**Please, flip page to continue**

. Consent of Administration of vaccine

------ Influenza (Flu shot)

- Have you ever had a flu shot before? ---- Yes ---- No

------ Hepatitis A

------ Hepatitis B

------ Measles, Mumps and Rubella

------ Tdap

------ Varicella

------ Gardasil 9

------ Pneumonia

------ Shingrix

------ Trumenba

Arm: right --- left ----

I have read, or have had read to me, the information regarding the vaccine/vaccines marked above. I have had the opportunity to ask questions that were answered to my satisfaction, I understand the benefits and risks of the vaccine/vaccines, I consent to OR give consent for the administration of the vaccine/vaccines marked above to:

Name (print): _____

Address: _____

Date of birth: _____

Signature: _____

| *To be filled out by the Pharmacist* |
| --- |
| Vaccine Lot number:<br>Expiration date:<br>Notes:<br>R.Ph. signature:<br>Date: |