River City Pharmacy LLC
2717 Spring Ave SW
Decatur, AL 35603
256-445-5400

IMMUNIZATION FORM

Patient's Last Name:	First:	Middle:	Date of Birth:
Delivery Address:	City:	State:	Zip Code:

Insurance Name: ID Number:

Please answer Questions **1-8 for a Influenza Vaccine** and Questions **1-6, 9,and 10 for pneumococcal Vaccine**:

		YES	NO
1.	Are you under the age of 18?	[ ]	[ ]
2.	Do you have a known or suspected pregnancy?	[ ]	[ ]
3.	Are you currently ill or have a fever?	[ ]	[ ]
4.	Are you currently on antibiotics?	[ ]	[ ]
5.	Do you have or ever had Guillain-Barre' Syndrome?	[ ]	[ ]
6.	Do you have an allergy to eggs?	[ ]	[ ]
7.	Have you ever had the influenza vaccine before?	[ ]	[ ]
8.	Have you ever had an allergic reaction to influenza vaccine?	[ ]	[ ]
9.	Have you ever had a pneumococcal vaccine? a. If Yes, when? ___________________________		
10.	Have you ever had an allergic reaction to the pneumococcal vaccine?	[ ]	[ ]

I have read or have had explained to me, information about Influenza/pneumococcal Vaccines. I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of receiving the influenza/Pneumonicccal vaccine and request that the vaccine be given to me, or to the person named for who I am authorized to make this request.

I acknowledge receiving the pharmacy's Notice of HIPPA privacy practices.

I wish to have River City Pharmacy LLC bill my insurance for the vaccination given. I authorize the release of any medical or other information necessary to process this claim. I request that payment of my insurance benefits be paid directly to River City Pharmacy LLC. If for any reason my insurance refuses payment to River City Pharmacy LLC, I realize that I will be liable for the full amount due to River City Pharmacy LLC and any expenses River City Pharmacy LLC may incur in collecting this debt.

____ ____________________________

Signature of person to receive vaccine or authorized to make the request **Date**

FOR PHARMACY USE ONLY

[ ] INFLUENZA/H1N1 VACCINATION **[ ] pneumococcal VACCINATION**

MANUFACTURER and VACCINE NAME:_________________________________**LOT NUMBER:**______________________

NDC#:____ **EXPIRATION DATE:**_____________________

SITE OF INJECTION: [ ] LEFT DELTOID **[ ] RIGHT DELTOID**

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