McDowell's Pharmacy

1004 Main Street
Scotland Neck, NC 27874
Phone: 252-826-4137
Fax: 252-826-4663

Name: _____ Gender: Male Female Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Allergies: _____ Race: _____

Primary Care Doctor: _____ Office Number: _____

Screening Questions

Email: _____

1.	Are you sick today?	Yes	No
2.	Do you have allergies to medications, food, eggs, yeast, a vaccine or vaccine component, or latex?	Yes	No
3.	Have you ever had a serious reaction after receiving a vaccination?	Yes	No
4.	Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	Yes	No
5.	Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?	Yes	No
6.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's Disease, herpes, or cold sores?	Yes	No
7.	In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	Yes	No
8.	Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	Yes	No
9.	During the past year, have you received a transfusion of blood or blood products, or been given Immune (gamma) globulin or an antiviral drug (including acyclovir, famciclovir, or valacyclovir)?	Yes	No
10.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No
11.	Have you received any vaccinations or TB skin tests in the past 4 weeks?	Yes	No
12.	Do you have a history of fainting, particularly with vaccines?	Yes	No
13.	**For Tdap and adult Td:** Do you have a cut, injury, puncture, or open wound that prompted you to get a tetanus shot?	Yes	No
14.	**For Zoster:** Have you had a past reaction to gelatin or triple antibiotic ointment?	Yes	No

Consent: I have read, or have had read to me, the written information regarding the vaccine(s) being administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of a current Vaccine Information Sheet. I certify that I am at least 18 years old and hereby give my consent to the pharmacists of this AmerisourceBergen Good Neighbor Pharmacy to administer the vaccine(s). If under 18 years old, signature by parent or guardian is required. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless AmerisourceBergen/Good Neighbor Pharmacy, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s). I agree to pay the full amount for the vaccine if my insurance plan does not cover the cost. **I agree to wait near the vaccination location for approximately 15 minutes for observation by the pharmacist.**

Name (print) _____ Signature _____ Date _____

Administration (Pharmacist Use Only)

Vaccine	Product Name	Manufacturer	Lot	Exp Date	Dose	Site of Injection	Date of VIS	Vaccine administrator signature
Herpes Zoster	shingrix	GSK			0.5 ml	LD RD	10/30/2019	
Influenza (QIV)	Afluria	Sequiris			0.5 ml	LD RD	08/06/2021	
Influenza (QIV)	Flucelvax	Sequiris			0.5 ml	LD RD	08/06/2021	
Influenza (HD)	Fluzone HD	Sanofi			0.7 ml	LD RD	08/06/2021	
Pneumococcal Conj.	Prevnar 13	Pfizer			0.5 ml	LD RD	10/30/2019	
Pneumococcal Polys.	Pneumovax 23	Merck			0.5 ml	LD RD	10/30/2019	
Tetanus, Dipth, AP	Boostrix	GSK			0.5 ml	LD RD	08/06/2021	

02/04/2008

North Carolina Immunization Registry

Organization: **NORTH CAROLINA IMMUNIZATION REGISTRY**

Site: **NORTH CAROLINA IMMUNIZATION REGISTRY**

Vaccine Administration Record

Information collected on this form will be used to document authorization for receipt of vaccine(s).

CHART NUMBER

Patient's Name (Last, First, Middle Initial)

	Date of Birth (mm/dd/yyyy)	Gender	Ethnicity (Check One)
		☐ Male ☐ Female	☐ Hispanic ☐ Non-Hispanic

Race (Check all that apply)
☐ American Indian or Alaskan Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African-American ☐ White ☐ Other Race ☐ Unknown

Mother's Maiden Name (Last, First, Middle Initial)

Eligibility Status (Check only one)
This section must be completed for children through age 18 given state-supplied vaccines.

☐ **American Indian /Alaskan Native**
☐ **Underinsured**
☐ **Refusal to give information**
☐ **Medicaid**
☐ **NC Health Choice**
☐ **Not applicable**
☐ **Not Insured**
☐ **Insured**

Date Last Verified (mm/dd/yyyy): _____/_____/_____

Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial)		Relationship to Patient	
Address		P.O. Box	
City	County	State	Zip Code
Email address (if applicable)	Home Telephone Number ( )	Work Telephone Number ( )	Extension
	Is reminder/recall contact allowed? ☐ Yes ☐ No	Would you like reminder/recall sent to you? ☐ Yes ☐ No	

I am authorized by the parent, guardian, or person standing in loco parentis of the above-named child to obtain needed immunizations for the child.

I/parental designee have received the "Vaccine Information Statements" (VIS) about the disease(s) and vaccine(s). I have had a chance to review the VIS(s) and to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request the vaccine(s) indicated below to be given to me or the person named above for whom I am authorized to make this request.

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

FOR OFFICE USE

Vaccine	Trade Name	Lot #	VIS Pub. Date	Date VIS Presented	Body Route	Body Site *	mL.
DTP/aP					IM	RV LV RD LD	
HepB					IM	RV LV RD LD	
Hib					IM	RV LV RD LD	
MMR					SC	RV LV RD LD	
Pneumo Conjugate 7					IM	RV LV RD LD	
Polio						RV LV RD LD	
Varicella					SC	RV LV RD LD	
Other							

*RV = Right Vastus Lateralis LV = Left Vastus Lateralis RD = Right Deltoid LD = Left Deltoid Subcutaneous injections are administered in the muscle "area".

SIGNATURE AND TITLE - Person Administering Vaccine	Date Vaccine Administered