# REMINGTON DRUG CO VACCINE REGISTRATION

## GUEST INFORMATION

| | |
|---|---|
| **Name:** | **Street Address:** |
| **Date of Birth:** | |
| **Age:** | **City, State:** |
| **Primary Physician:** | **Zip Code:** |
| **Allergies:** | **Phone:** |

## A FEW QUESTIONS FOR YOU

| | YES | NO |
|---|---|---|
| 1. Have you ever fainted or felt dizzy after receiving a shot? | ☐ | ☐ |
| 2. Are you pregnant or is there a chance you could be pregnant? | ☐ | ☐ |
| 3. Are you sick today or have a fever? | ☐ | ☐ |
| 4. Did you receive the flu vaccine last year? | ☐ | ☐ |
| 5. Do you have a brain or nerve disorder such as Guillain-Barre or have you developed such disorder after receiving a vaccine? | ☐ | ☐ |
| 6. Have you ever had a seizure? | ☐ | ☐ |
| 7. Have you ever had a serious reaction to a vaccine? | ☐ | ☐ |
| 8. Do you or anyone in your household take prednisone, any steroid, anti-cancer drugs, or have radiation or X-ray treatment? | ☐ | ☐ |
| 9. Do you or anyone in your household have cancer, leukemia, HIV/AIDS, care for a child, or have any problem that could affect your immune system? | ☐ | ☐ |
| 10. Are you allergic to any of the following: eggs, yeast, streptomycin, neomycin, thimerosal, any vaccine, or vaccine component? | ☐ | ☐ |

Please CIRCLE the vaccine you wish to receive: (FLU) PNEUMONIA SHINGLES OTHER:_____

*"I have read or have had explained to me written information about the vaccine listed below. I have also received a written VIS form concerning the vaccine that I wish to receive. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine being administered and authorize the administration of the vaccine to me or to the person named below for whom I am authorized to make this decision. I also authorize that I will give consent to blood draws in the case that a pharmacy employee is exposed to blood products in which the results will only be provided to you as a patient, the employee, and the employee's healthcare provider."*

Signature: _____ Date: _____

| Pharmacist Use Only | | | |
|---|---|---|---|
| Vaccine Name<br>Manufacturer | Lot Number<br>Expiration | Site and Route of Vaccine | Administered By (Name / Title) and Date |
| Fluad Seqirus<br>Fluarix GSK<br>Flucelvax Seqirus | 370680 5/16/24<br>AF749 6/30/24<br>370658 6/23/24 | IM Sub-Q<br>(Deltoid)<br>L R | TRAVIS HALE, PHARMD DATE:_____<br>AL ROBERTS, BPHARM DATE:_____<br>MARGARET ROWE, PHARMD DATE:_____<br>WENDY LEAR, PHARMD DATE:_____ |
| Gave VIS Form [ ] • Entered Information into state registry [ ] • Faxed to Primary Dr [ ] • Scanned into Profile [ ] | | | |

## ADDITIONAL QUESTIONS

*The following questions will allow us to help you improve your health in the future.*

1. Do you have any of the following conditions? (*please circle all that apply*)
   Diabetes Heart Failure Blood Pressure COPD Asthma Other:_____

2. Are you interested in discovering other immunizations that you may qualify for?
   YES NO

3. Are you a healthcare worker?
   YES NO

4. Do you work in a school, daycare, or other institutional setting?
   YES NO

5. Are you planning any international travel in the coming year?
   YES NO

## COVID-19 PRE-SCREENING QUESTIONS

1. Do you have a fever or above-normal temperature (>100.4°F)?
   YES NO Actual Temp:_____ Staff Initial:_____

2. Are you experiencing shortness of breath or having trouble breathing?
   YES NO

3. Do you have a dry cough?
   YES NO

4. Even if you currently don't have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?
   YES NO

5. Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?
   YES NO

6. Have you traveled more than 100 miles from your home in the last 14 days?
   YES NO

**Patient Signature Required at Appointment**:
I agree to notify the pharmacy within 14 days if I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the pharmacy has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days.

Signature: _____ Date: _____