REMINGTON DRUG CO VACCINE REGISTRATION

GUEST INFORMATION

Name:	**Street Address:**
Date of Birth:	**City, State:**
Age:	**Zip Code:**
Primary Physician:	**Mother's Maiden Name:**
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. Do you have a bleeding disorder, or do you take a blood thinner?	☐	☐
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, polyethylene glycol, polysorbate, any vaccine, or vaccine component?	☐	☐

Please CIRCLE the vaccine you wish to receive: COVID ● FLU ● PNEUMO ● SHINGLES ● TETANUS ● RSV

"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 Manufacturer Fluarix GSK Fluad Seqirus _____ _____	Lot Number Expiration AF749 6/30/24 370680 5/16/24 _____ _____	Site and Route of Vaccine IM Delt L or R IM Delt L or R IM Delt L or R IM Delt L or R	Administered By (Name) and Date TRAVIS HALE, PHARMD DATE:_____ AL ROBERTS, BPHARM DATE:_____ MARGARET ROWE, PHARMD DATE:_____ WENDY LEAR, PHARMD DATE:_____
Gave VIS Form [ ] ● Entered Information into state registry [ ] ● Faxed to Primary Dr [ ] ● Scanned into Profile [ ]			