

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 Manufacturer	Lot Number Expiration	Site and Route of Vaccine	Administered By (Name / Title) and Date
Fluad Seqirus Fluarix GSK Flucelvax Seqirus	407245 4/28/26 B59DH 6/30/26 406988 5/4/26	IM Sub-Q L Deltoid R	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 []			

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?