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
		IM Sub-Q Deltoid L 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?
   YES NO