TEL 215-674-5050 HORSHAM SQUARE PHARMACY & WELLNESS CENTER FAX 215-957-5874
575 HORSHAM RD UNIT C20 HORSHAM, PA 19044

Section 1: Information about Patient to Receive Vaccine (please print) Please bring your insurance cards or a copy of them with you!

PATIENT'S NAME (Last)	(First)	(M.I.)	PATIENTS'S DATE OF BIRTH month________ day_______ year _________	
ADDRESS			PATIENTS'S GENDER M or F	PATIENT'S AGE
CITY STATE ZIP			Cell Phone:	

Please check your Race: □ Native American □ Alaska Native □ Asian □ Black □ African American □ White □ Other □ Pacific Islander □ Native Hawaiian **Are you** □ Hispanic/Latino □ Not Hispanic/Latino

RX BIN # ____________________ **RX PCN #** ____________________**RX GRP #** ____________________ **ID #**_______________________

MEDICARE PART B ID# _______________________________ **Last 4 of SS #** ___________________________

Question: Please answer each question	Yes	No	Not Sure
1. Are you sick today or have you been sick in the last 2 weeks?			
2. Do you have allergies to medications, food, a vaccine ingredient, or latex?			
3. Have you ever had a serious reaction after receiving a vaccine?			
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease, asthma, a blood clotting disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on a long-term aspirin therapy?			
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
6. Do you have a parent, brother, or sister with an immune system problem?			
7. In the past 3 months, have you taken medicines that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?			
8. Have you had a seizure, brain or other nervous system problem?			
9. During the past year, have you received a transfusion of blood or blood products?			
10. Are you pregnant or is there a chance you could become pregnant during the next month?			
11. Have you received any vaccinations in the past 2 weeks?			
12. Have you have received all the following vaccines: Pneumococcal, Shingles, and Tdap?			

√	Vaccine(please select up to 2 vaccines)	Abbrevs.	Trade name(s)
	Respiratory Syncytial Virus	RSV	Arexvy, Abrysvo
	COVID-19 vaccine	COV-PF	Pfizer-BioNTech COVID-19 Vaccine, Bivalent
	COVID-19 vaccine	COV-MOD	Moderna COVID-19 Vaccine, Bivalent
	Hepatitis A and hepatitis B vaccine	HepA-HepB	Twinrix®
	Hepatitis B vaccine	HepB	Engerix-B®, HEPLISAV-B, PREHEVRIO, RECOMBIVAX HB
	Influenza vaccine (inactivated)	FLU	Fluarix, Flulaval, Fluzone, Afluria, Fluad, Flucelvax
	Pneumococcal conjugate vaccine	PCV20	Prevnar 20™
	Pneumococcal polysaccharide vaccine	PPSV23	Pneumovax 23®
	Tetanus & diphtheria toxoids & acellular pertussis	Tdap	ADACEL OR BOOSTRIX
	Zoster vaccine, recombinant	RZV	Shingrix

Please continue onto back side of form

Consent for services: I have been provided with the Vaccine Information Sheets or patient fact sheet corresponding to the vaccine that I am receiving. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me or to the person named above for whom I am authorized to make the request. All VIS forms are available in the pharmacy and you may access all forms with your cell phone as well.
Authorization to request payment: I do hereby authorize Horsham Square Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or my prescription insurance. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.
Disclosure of records: I understand that Horsham Square Pharmacy may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at Horsham Square Pharmacy, my Primacy Care Physician, my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or understand that Horsham Square Pharmacy will use and disclose my health information asset forth in their Notice of Privacy Practices (copy available in store).

Dr. James Mahoney has authorizations for all vaccines given by Horsham Square Pharmacy. The master copy is located in the pharmacy.

Signature of Patient/Parent/Legal Guardian____

Date: ____

Abbrevs.	Vaccine Used	Lot #	Manufacturer
RSV			
COV-PF			
COV-MOD			
HepA-HepB			
HepB			
FLU			
PCV20			
PPSV23			
Tdap			
RZV (Shingrix)			

Name & Title of Vaccine Administrator:________________________________

Date of Administration: ____

Route of Administration: L or R arm IM other______________