HORSHAM SQUARE PHARMACY

575 Horsham Rd. Unit C-20, Horsham PA 19044

Patient name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Cellphone: _____ Email: _____

Birth Date: _____/_____/_____ Gender: - Male ☐ Female ☐ Other ☐ Approx Weight: _____Lbs.

Vaccine wanted: -	Flu 65 +	Flu Regular	Moderna	Pfizer	Shingles	RSV	CAPVAXIVE	TDAP	Hep A/B
VIS Date:	8/6/21	8/6/21	10/19/23	10/19/23	2/4/22	10/19/23	5/29/25	8/6/21	10/15/21; 5/12/23

Primary Doctor Name & Phone Number: _____ Social Security _____

Ethnicity: Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Medicare Care ID # _____

Race: - American Indian ☐ Asian ☐ Native Hawaiian ☐ Black or African American ☐ White ☐ Other ☐

For Patients: The following questions will help us determine which vaccines you may be given today. If you answer "Yes" to any question, It Does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are You Sick Today?	☐	☐	☐
2. Do You Have Allergies to Medications, Food, A Vaccine Component, or Latex?	☐	☐	☐
3. Have You Ever Had a Serious Reaction After Receiving a Vaccination?	☐	☐	☐
4. Do You Have a Long-Term Health Problem with Heart Disease, Lung Disease, Asthma, Kidney Disease, Metabolic Disease (E.G. Diabetes) Anemia, or Other Blood Disorder?	☐	☐	☐
5. Do You Have Cancer, Leukemia, Aids, Or Any Other Immune System Problem?	☐	☐	☐
6. Do You Take Cortisone, Prednisone, Other Steroids, or Anticancer Drugs?	☐	☐	☐
7. Have You Had Seizure or A Brain or Other Nervous System Problem?	☐	☐	☐
8. During The Past Year, Have You Received a Transfusion of Blood or Blood Products, or Been Given Immune (Gamma) Globulin or An Antiviral Drug?	☐	☐	☐
9. For Women: Are You Pregnant or Is There a Chance You Could Become Pregnant During Next Month?	☐	☐	☐
10. Have You Received Any Vaccinations in The Past 4 Weeks?	☐	☐	☐

I Authorize the Pharmacist to Send Copies of My Vaccine Documents to My Primary Care Provider.

Signature _____ Date: _____/_____/_____

Form Completed By (For Minors Only) Signature_____ Date: _____/_____/_____

For Pharmacy Use Only

Form Reviewed By: _____ Site: L / R Deltoid IM

Place vaccine information label here.

APPLY Rx LABEL HERE

Please *Continue onto Back side* of the Form and SIGN!!

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 Primary 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 as set 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: _____