WARREN'S DRUG STORE

"Experience Independent Pharmacy Care At Its Best"

IMMUNIZATION ADMINISTRATION RECORD

NAME _____ DATE OF BIRTH _____

ADDRESS _____ LAST 4 DIGITS OF SS#_____

CITY _____ STATE _____ ZIP _____ Phone# (_____) _____ - _____

Have you ever had a severe reaction to a previous vaccination?	YES	NO
Do you have any allergies to medications, latex, yeast, eggs, gelatin, Neomycin, or thimerosal?	YES	NO
Are you sick today or do you currently have a fever, diarrhea, vomiting or infection	YES	NO
Have you had a flu vaccine before	YES	NO
Have you had a pneumonia vaccine before	YES	NO
Are you currently under the care of Hospice	YES	NO
Do you have any CHRONIC health conditions? If yes, please list:_____	YES	NO
WOMEN ONLY: Is it possible that you are pregnant or may become pregnant within 3 month	YES	NO

I hereby authorize Warren's Drug Store to bill Medicare Part B/Part D or my private insurance plan on my behalf. I request that payment of authorized benefits, including administration, be made to Warren's Drug Store for the vaccine(s) marked below.

I have read, or have had read to me, the written information regarding the vaccine(s) marked below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have the right to be provided, upon request, a copy of a current Vaccine Information Sheet for each vaccine I have received today. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Warren's Drug Store, Inc, its affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) marked below. I certify that I am at least 18 years old and hereby give my consent to the pharmacists of Warren's Drug Store to administer the vaccine(s) marked below. If under 18 years old signature by parent or guardian required. I agree that I have the option to wait near the vaccination location for approximately 15 minutes for observation by the staff of Warren's Drug Store.

SIGNATURE _____

VACCINE ADMINISTERED

INFLUENZA _____ PREVNAR-13 PNEUMOVAX-23 SHINGRIX ZOSTAVAX Tdap OTHER*

If you are receiving an Influenza vaccine, please answer the following questions:
-Have you ever had a Pneumonia vaccine? Prevnar-13 Pneumovax-23 YES NO If so, when? ___/___/_____ (if available)
-Are you interested in a Shingles vaccine (Shingrix)? YES NO

*(Other)_____ MANUFACTURER _____

DOSE: _____ LOT # _____ EXP DATE _____

SITE OF INJECTION LD RD DATE ADMINISTERED _____

SIGNATURE OF ADMINISTRATOR OF VACCINE _____

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